COMMONWEALTH OF VIRGINIA
DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

COMMONWEALTH COORDINATED CARE PLUS PROGRAM

MODEL MEMBER HANDBOOK

Effective January 1, 2018

Customizing the Member Handbook
Instructions for CCC Plus Plans

The Commonwealth Coordinated Care Plus (CCC Plus) Program Member Handbook Template is to be used as the base handbook by all CCC Plus Plans. Plans must fill in areas that reference plan specific information, for example plan contact information, referral and service authorization requirements, enhanced benefits, and plan specific instructions to empower Members to access their care and services. Information added by plans should be person-centered. Plans must contact DMAS to discuss any changes outside of the instructions listed below with respect to customization or improvements, including for example content that is believed to be missing or ambiguous or incorrect. Plans do not need to obtain DMAS approval to correct typographical errors; however, plans should communicate any such errors to DMAS for correction in subsequent revisions.

Plans may customize the base handbook with plan specific information as described in the handbook and below. Plans have the option to do all of the following:

- ✓ Use plan specific branded templates.
- ✓ Add the plan logo and resize / position the CCC Plus logo. The aspect of the logo should not be changed/distorted. (Resize from the corner).
- ✓ Add pictures, text boxes or bubbles that highlight important content.
- ✓ Revise the front cover.
- ✓ Relocate or otherwise include important phone numbers inside front or back cover for easy reference.
- ✓ Move the *Help in Other Languages* information to the inside of the front cover.
- ✓ Revise the layout as long as the base content remains unchanged, and the font remains at least 14-point. At least 18-point font must be used for sections related to getting materials or help in alternate formats.
- ✓ Change the content of the footer to reflect the hours of operation for Member Services, for example if the plan's Member Services Department is available 24/7/365.
- ✓ Customize in the appropriate sections where the plan provides enhanced services.
- ✓ Add additional specific details as noted in the plan instructions throughout the handbook.
- ✓ Revise the format for phone numbers; plans do not have to use the table format for example on page 30 as long as the required content is included.

About the fonts used in this document: If you plan to update using the existing font/format, the body of the document is in "Style 2" or 14 Font Calibri, multiple spacing @ 1.15; 6 spacing (before and after). The table of contents is built from the headers. Section headings used is "1 Heading"; subsection headings used are "2 Heading" or "Heading 3" or 4 Heading." This version incorporates recommendations from health plans and stakeholders. Plans should delete all "plan instruction" references from their final handbooks.

Where To Find Information

Help in Other Languages or Alternate Formats

This handbook is available for free in other languages and formats including on-line, in large print, Braille or Audio CD. To request the handbook in an alternate format and or language *[plan inserts instructions on how to make the request.]*

If you have any problems reading or understanding this information, please contact our Member Services staff at <1-8xx-xxx-xxxx> (TTY 1-xxx-xxx-xxxx) for help at no cost to you.

We provide reasonable accommodations and communications access to persons with disabilities. Individuals who are deaf or hard of hearing or who are speech-impaired, who want to speak to a Member Services representative, and who have a TTY or other assistive device can dial 711 to reach a relay operator. They will help you reach our Member Services staff. *Plan includes instructions for how individuals who are deaf or hard of hearing or speech impaired and do not have TTY can reach Member Services Staff.*

Help in Other Languages

ATTENTION: If you do not speak English, language assistance services, free of charge, are available to you. Call *1- xxx-xxx-xxxx (TTY: 1- xxx-xxx-xxxx).*

Spanish

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-xxx-xxx-xxxx (TTY: 1-xxx-xxx-xxxx).

Korean

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-xxxxxx-xxxx (TTY: 1-xxx-xxx-xxxx)번으로 전화해 주십시오.

Vietnamese

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dị ch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-xxxxxx-xxxx (TTY: 1-xxx-xxx-xxxx)

Chinese

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-xxx-xxx-xxxx（TTY：1- xxx-xxx-xxxx）

Arabic

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-xxxx-xxx-xxx) رقم هاتف الصم والبكم: 1-xxx-xxx-xxxx)

Tagalog

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-xxx-xxx-xxxx (TTY: 1-xxx-xxx-xxxx).

Farsi

توجه: اگر فارسی زبان بھ می باشد. با 1-xxx-xxx-xxxx (TTY: 1-xxx-xxx-xxxx) تماس بگیرید. شما برای رایگان بصورت زبانی تسهیلات، کنید می گفتگو

Amharic

ማስታወሻ: የሚናገሩት ቋንቋ ኣማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 1-xxx-xxx-xxxx (መስማት ለተሳናቸው: 1-xxx-xxx-xxxx).

Urdu

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-xxx-xxx-xxxx. (رقم هاتف الصم والبكم: 1-xxxx-xxx-xxxx)

French

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-xxx-xxx-xxxx (ATS : 1-xxx-xxx-xxxx).

Russian

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-xxx-xxx-xxxx (телетайп: 1-xxx-xxx-xxxx).

Hindi

ध्यान द: यद आप हदी बोलते ह तो आपके िलए मुफ्त म भाषा सहायता सेवाएं उपलब्ध ह। 1-xxx-xxx-xxxx (TTY: 1-xxx-xxx-xxxx) पर कॉल कर।

German

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-xxx-xxx-xxxx (TTY: 1-xxx-xxx-xxxx).

Bengali

লয্ করনঃ যিদ আপিন বাংলা, কথা বলেত পাের্রন, তাহেল িনঃখরচায় ভাষা সহায়তা পিরেষবা উপল ৈআছ। ের্ফান করন ১-xxx-xxx-xxxx (TTY: ১-xxx-xxx-xxxx)।

Bassa

Dè ɖɛ nìà kɛ dyéɖé gbo: Ɔjǔ ké m̀ [Bàs -wùɖù-po-ny] jǔ ní, nìí, à wuɖu kà kò ɖò po-po bɛ ìn m̀ gbo kpáa. Đá 1-xxx-xxx-xxxx (TTY:1-xxx-xxx-xxxx)

1. Commonwealth Coordinated Care Plus (CCC Plus)

Welcome to [Plan]

Thank you for being a Member of [Plan], a Commonwealth Coordinated Care Plus (CCC Plus) plan. If you are a new Member, we will get in touch with you in the next few weeks to go over some very important information with you. You can ask us any questions you have, or get help making appointments. If you need to speak with us right away or before we contact you, call us at the number listed below.

[Plan can include additional language about itself and a "getting started" section that provides the things members should do first (example: top 3-5 things they should do first.]

How to Use This Handbook

This handbook will help you understand your Commonwealth Coordinated Care Plus (CCC Plus) benefits and how you can get help from [Plan]. This handbook is your guide to health services. It explains your health care, behavioral health, prescription drug, and long-term services and supports coverage under the CCC Plus program. It tells you the steps you can take to make your health plan work for you.

Feel free to share this handbook with a family member or someone who knows your health care needs. When you have a question, check this handbook, call our Member Services unit, visit our website at < > or call your Care Coordinator.

Other Information We Will Send to You

You should have already received your [Plan] Member ID Card, and information on how to access a Provider and Pharmacy Directory, and a List of Covered Drugs. *[Plan should insert* information about how to access all of these references. Plan includes information on any other resources to be sent to the Member.]

[Plan] Member ID Card

Show your [Plan] ID card when you receive Medicaid services, including when you get long term services and supports, at doctor visits, and when you pick up

prescriptions. You must show this card when you get any services or prescriptions. If you have Medicare and Medicaid, show your Medicare and [plan] ID card when you receive services. Below is a sample card to show you what yours will look like:

[*Insert picture of front and back of Member ID Card. Mark it as a sample card (for example, by superimposing the word "sample" on the image of the card).*]

If you haven't received your card, or if your card is damaged, lost, or stolen, call Member Services at the number at the bottom of the page right away, and we will send you a new card.

In addition to your [plan] card, keep your Commonwealth of Virginia Medicaid ID card to access services that are covered by the State, under the Medicaid fee-for-service program. These services are described in *Services Covered through Medicaid Fee-For-Service,* in Section 11 of this handbook.

Provider and Pharmacy Directory

Plan adds instructions related to: You can ask for an annual Provider and Pharmacy Directory by calling Member Services at the number at the bottom of this page. You can also see the Provider and Pharmacy Directory at [plan info].

The *Provider and Pharmacy Directory* provides information on health care professionals (such as doctors, nurse practitioners, psychologists, etc.), facilities (hospitals, clinics, nursing facilities, etc.), support providers (such as adult day health, home health providers, etc.), and pharmacies in the [Plan] network. While you are a Member of our plan, you generally must use one of our network providers and pharmacies to get covered services. There are some exceptions, however, including:

- When you first join our plan (see *Continuity of Care Period* in Section 3 of this handbook),
- If you have Medicare (see *How to Get Care From Your Primary Care Physician* in Section 6 of this handbook, and
- In several other circumstances (see *How to Get Care From Out-of-Network Providers* in Section 6 of this handbook.)

You can ask for a paper copy of the *Provider and Pharmacy Directory or List of Covered Drugs* by calling Member Services at the number at the bottom of the page. You can also see the *Provider and Pharmacy Directory and List of Covered Drugs* at <web address> or download it from this website. Refer to *List of Covered Drugs* in Section 9 of this handbook.

[*Plans must add information describing the information available in the directory*.]

Important Phone Numbers

Plans can relocate this to inside front or back cover for easy reference.

Your Care Coordinator	
[Plan] Member Services	
[Plan] 24/7 Medical /Behavioral Health Advice Line	
[Plan] 24/7 Behavioral Health Crisis Line	
[Plan] Adult Dental (if offered)	
Smiles for Children through DentaQuest, DMAS Dental Benefits Administrator	For questions or to find a dentist in your area, call *Smiles For Children* at 1-888-912-3456. Information is also available on the DMAS website at: http://www.dmas.virginia.gov/Content_pgs/dnt-home.aspx

	or the DentaQuest website at: http://www.dentaquestgov.com/
[Plan] Transportation	
DMAS Transportation Contractor for transportation to and from DD Waiver Services	1-866-386-8331 TTY 1-866-288-3133 Or dial 711 to reach a relay operator
CCC Plus Helpline	1-844-374-9159 TDD: 1-800-817-6608 or visit the website at cccplusva.com.
Department of Health and Human Services' Office for Civil Rights	1-800-368-1019 or visit the website at www.hhs.gov/ocr
Office of the State Long-Term Care Ombudsman	1-800-552-5019 TTY 1-800-464-9950

2. What is Commonwealth Coordinated Care Plus

The Commonwealth Coordinated Care Plus (CCC Plus) program is a Medicaid managed care program through the Department of Medical Assistance Services (DMAS). [Plan] was approved by DMAS to provide care coordination and health care services. Our goal is to help you improve your quality of care and quality of life.

What Makes You Eligible to be a CCC Plus Member

You are eligible for CCC Plus when you have full Medicaid benefits, and meet one of the following categories:

- You are age 65 and older,
- You are an adult or child with a disability,
- You reside in a nursing facility (NF),
- You receive services through the CCC Plus home and community based services waiver [formerly referred to as the Technology Assisted and Elderly or Disabled with Consumer Direction (EDCD) Waivers],
- You receive services through any of the three waivers serving people with developmental disabilities (Building Independence, Family & Individual Supports, and Community Living Waivers), also known as the DD Waivers.

CCC Plus Enrollment

Eligible individuals must enroll in the CCC Plus program. DMAS and the CCC Plus Helpline manage the enrollment for the CCC Plus program. To participate in CCC Plus, you must be eligible for Medicaid.

Reasons You Would Not be Eligible to Participate in CCC Plus

You would not be able to participate in CCC Plus if any of the following apply to you:

- You lose/lost Medicaid eligibility.
- You do not meet one of the eligible categories listed above.

- You are enrolled in hospice under the regular fee-for-service Medicaid program prior to any CCC Plus benefit assignment.
- You enroll in the Medicaid Health Insurance Premium Payment (HIPP) program.
- You enroll in PACE (Program of All-Inclusive Care for the Elderly). *For more information about PACE, talk to your Care Coordinator or visit:* http://www.dmas.virginia.gov/Content_pgs/ltc-pace.aspx.
- You enroll in the Medicaid Money Follows the Person (MFP) Program. *For more information about MFP, talk to your Care Coordinator or visit:* http://www.dmas.virginia.gov/Content_pgs/ltc-mfp.aspx.
- You enroll in the Alzheimer's Assisted Living Waiver. This waiver will end on June 30, 2018. Members with Alzheimer's may participate in CCC Plus when they are no longer enrolled in the Alzheimer's Assisted Living Waiver or when the Waiver ends. *For more information about the Alzheimer's Waiver, talk to your Care Coordinator or visit:* *http://www.dmas.virginia.gov/Content_pgs/ltc-wvr_aal.aspx*.
- You reside in an Intermediate Care Facility for Individuals with Intellectual and Developmental Disabilities (ICF/IID).
- You are receiving care in a Psychiatric Residential Treatment Facility (children under age 21).
- You reside in a Veteran's Nursing Facility.
- You reside in one of these State long term care facilities: Piedmont, Catawba, Hiram Davis, or Hancock.

What if I Am Pregnant

[Plan describes prenatal program and services.]

If you are within your first ninety (90) days of initial enrollment, and in your 3rd trimester of pregnancy, and your provider (including midwife) is not participating with *<Plan>,* you may request to move to another MCO where your provider participates. If your provider does not participate with any of the CCC Plus health

plans, you may request to receive coverage through fee-for-service Medicaid until after delivery of your baby. Contact the CCC Plus Helpline at 1-844-374-9159 or TDD: 1-800-817-6608 to make this request.

Coverage for Newborns Born to Moms Covered Under CCC Plus

If you have a baby, you will need to report the birth of your child as quickly as possible to enroll your baby in Medicaid. You can do this by:

- Calling the Cover Virginia Call Center at 1 (855) 242-8282 to report the birth of your child over the phone, or
- Contacting your local Department of Social Services to report the birth of your child.

You will be asked to provide your information and your baby's:

- Name
- Date of Birth
- Race
- Gender
- The baby's mother's name and Medicaid ID number

When first enrolled in Medicaid, your baby will be able to access health care through the Medicaid fee-for-service program. This means that you can take your baby to any provider in the Medicaid fee-for-service network for covered services. Look for additional information in the mail about how your baby will receive Medicaid coverage from DMAS.

Medicaid Eligibility

Medicaid eligibility is determined by your local Department of Social Services (DSS) or the Cover Virginia Central Processing Unit. Contact your local DSS eligibility worker or call Cover Virginia at 1-855-242-8282 or TDD: 1-888-221-1590 about any Medicaid eligibility questions. The call is free. For more information you can visit Cover Virginia at www.coverva.org.

Choosing or Changing Your Health Plan

Health Plan Assignment

You received a notice from DMAS that included your initial health plan assignment. With that notice DMAS included a comparison chart of health plans in your area. The assignment notice provided you with instructions on how to make your health plan selection.

You may have chosen us to be your health plan. If not, DMAS may have assigned you to our health plan based upon your history with us as your managed care plan. For example, you may have been enrolled with us before either through Medicare or Medicaid. You may also have been assigned to us if certain providers you see are in our network. These include nursing facilities, adult day health care, and private duty nursing providers.

You Can Change Your Health Plan Through the CCC Plus Helpline

The CCC Plus Helpline can help you choose the health plan that is best for you. For assistance, call the CCC Plus Helpline at 1-844-374-9159 or TDD 1-800-817-6608, or visit the website at cccplusva.com. The CCC Plus Helpline is available Monday through Friday (except on State Holidays) from 8:30 am to 6:00 pm. The CCC Plus Helpline can help you understand your health plan choices and answer your questions about which doctors and other providers participate with each health plan. The CCC Plus Helpline services are free and are not connected to any CCC Plus health plan.

You can change your health plan during the first 90 days of your CCC Plus program enrollment for any reason. You can also change your health plan once a year during open enrollment for any reason. Open enrollment occurs each year between October and December with a January 1st coverage begin date. You will get a letter from DMAS during open enrollment with more information. You may also ask to change your health plan at any time for "good cause," which can include:

- You move out of the health plan's service area,
- You need multiple services provided at the same time but cannot access

them within the health plan's network,

- Your residency or employment would be disrupted as a result of your residential, institutional, or employment supports provider changing from an in-network to an out-of-network provider, and
- Other reasons determined by DMAS, including poor quality of care and lack of access to appropriate providers, services, and supports, including specialty care.

The CCC Plus Helpline handles "good cause" requests and can answer any questions you may have. Contact the CCC Plus Helpline at 1-844-374-9159 or TDD 1-800-817-6608, or visit the website at cccplusva.com.

Automatic Re-Enrollment

If your enrollment ends with us and you regain eligibility for the CCC Plus program within 60 days or less, you will automatically be reenrolled with [Plan]. You will also be sent a re-enrollment letter from DMAS.

What is [Plan's] Service Area

[Insert plan service area here or within an appendix. Example: Our service area includes these cities and counties.]

Only people who live in our service area can enroll with [Plan]. If you move outside of our service area, you cannot stay in this plan. If this happens, you will receive a letter from DMAS asking you to choose a new plan. You can also call the CCC Plus Helpline if you have any questions about your health plan enrollment. Contact the CCC Plus Helpline at 1-844-374-9159 or TDD 1-800-817-6608 or visit the website at cccplusva.com.

If You Have Medicare and Medicaid

If you have Medicare and Medicaid, some of your services will be covered by your Medicare plan and some will be covered by [Plan]. We are your CCC Plus Medicaid Plan.

Types of Services Under Medicare	Types of Services Under CCC Plus (Medicaid)

- Inpatient Hospital Care (Medical and Psychiatric)
- Outpatient Care (Medical and Psychiatric)
- Physician and Specialists Services
- X-Ray, Lab Work and Diagnostic Tests
- Skilled Nursing Facility Care
- Home Health Care
- Hospice Care
- Prescription Drugs
- Durable Medical Equipment
- *For more information, contact your Medicare Plan, visit Medicare.gov, or call Medicare at 1-800-633-4227.*
- Medicare Copayments
- Hospital and Skilled Nursing when Medicare Benefits are Exhausted
- Long term nursing facility care (custodial)
- Home and Community Based Waiver Services like personal care and respite care, environmental modifications, and assistive technology services
- Community Behavioral Health Services
- Medicare non-covered services, like some over the counter medicines, medical equipment and supplies, and incontinence products.

You Can Choose the Same Health Plan for Medicare and Medicaid

You have the option to choose the same health plan for your Medicare and CCC Plus Medicaid coverage. The Medicare plan is referred to as a *Dual Special Needs Plan (D-SNP).* Having the same health plan for Medicare and Medicaid will enhance and simplify the coordination of your Medicare and Medicaid benefits. There are benefits to you if you are covered by the same health plan for Medicare and Medicaid. Some of these benefits include:

- You receive better coordination of care through the same health plan.
- You have one health plan and one number to call for questions about all of your benefits.
- You work with the same Care Coordinator for Medicare and Medicaid. This person will work with you and your providers to make sure you get the care you need.

[*Insert any enhanced benefits offered for Members that select your plan for Medicare and Medicaid*]

If you choose Medicare fee-for-service or a Medicare plan other than our Medicare D-SNP plan, we will work with your Medicare plan to coordinate your benefits.

How to Contact the Medicare State Health Insurance Assistance Program (SHIP)

The State Health Insurance Assistance Program (SHIP) gives free health insurance counseling to people with Medicare. In Virginia, the SHIP is called the Virginia Insurance Counseling and Assistance Program (VICAP). You can contact the Virginia Insurance Counseling Assistance Program if you need assistance with your **Medicare health insurance options.** VICAP can help you understand your Medicare plan choices and answer your questions about changing to a new Medicare plan. VICAP is an independent program that is free and not connected to any CCC Plus health plans.

CALL	1-800-552-3402 This call is free.
TTY	TTY users dial 711
WRITE	Virginia Insurance Counseling and Assistance Program 1610 Forest Avenue, Suite 100 Henrico, Virginia 23229
EMAIL	aging@dars.virginia.gov
WEBSITE	http://www.vda.virginia.gov/vicap2.asp

3. How CCC Plus Works

[Plan] contracts with doctors, specialists, hospitals, pharmacies, providers of long term services and supports, and other providers. These providers make up our provider network. You will also have a Care Coordinator. Your Care Coordinator will work closely with you and your providers to understand and meet your needs. Your Care Coordinator will also provide you with information about your covered services and the choices that are available to you. Refer to *Your Care Coordinator* in Section 4 of this handbook.

What are the Advantages of CCC Plus

CCC Plus provides person-centered supports and coordination to meet your individual needs. Some of the advantages of CCC Plus include:

- You will have a care team that you help put together. Your care team may include doctors, nurses, counselors, or other health professionals who are there to help you get the care you need.
- You will have a Care Coordinator. Your Care Coordinator will work with you and with your providers to make sure you get the care you need.
- You will be able to direct your own care with help from your care team and Care Coordinator.
- Your care team and Care Coordinator will work with you to come up with a care plan specifically designed to meet your health and/or long term support needs. Your care team will be in charge of coordinating the services you need. This means, for example:
    - Your care team will make sure your doctors know about all medicines you take so they can reduce any side effects.
    - Your care team will make sure your test results are shared with all your doctors and other providers so they can be kept informed of your health status and needs.
- Treatment choices that include preventive, rehabilitative, and community-based care.

- An on-call nurse or other licensed staff is available 24 hours per day, 7 days per week to answer your questions. We are here to help you. You can reach us by calling the number at the bottom of this page. Also refer to *Medical Advice Line Available 24 Hours a Day, 7 Days a Week* in Section 5 of this handbook.

What are the Advantages of Choosing [Plan]

[*Plan can include language about [Plan] and any enhanced benefits and services.*]

Continuity of Care Period

For Member's enrolled before April 1, 2018, the continuity of care period is 90 days. For Member's enrolled on and after April 1, 2018, the continuity of care period is 30 days.

If You Become Enrolled Before April 1, 2018

For Member's enrolled before April 1, 2018, the continuity of care period is 90 days. If *[Plan]* is new for you, you can keep seeing the doctors you go to now for the first 90 days. You can also keep getting your authorized services for the duration of the authorization or for 90 days after you first enroll, whichever is sooner. After 90 days in our plan, you will need to see doctors and other providers in the [Plan] network. A network provider is a provider who contracts and works with our health plan.

If you are in a nursing facility at the start of the CCC Plus Program, you may choose to

- Remain in the facility as long as you continue to meet the Virginia DMAS' criteria for nursing facility care,
- Move to a different nursing facility, or
- Receive services in your home or other community based setting.

The continuity of care period may be longer than 90 days. *<Plan>* may extend this time frame until the health risk assessment is completed. *<Plan>* will also extend this time frame for you to have a safe and effective transition to a qualified provider within our network. Talk to your Care Coordinator if you want to learn

more about these options.

Beginning April 1, 2018

For Member's enrolled on and after April 1, 2018, the continuity of care period is 30 days. If *[Plan]* is new for you, you can keep seeing the doctors you go to now for the first 30 days. You can also keep getting your authorized services for the duration of the authorization or for 30 days after you first enroll, whichever is sooner. After 30 days in our plan, you will need to see doctors and other providers in the [Plan] network. A network provider is a provider who contracts and works with our health plan.

If you are in a nursing facility at the start of the CCC Plus Program, you may choose to

- Remain in the facility as long as you continue to meet the Virginia DMAS' criteria for nursing facility care,
- Move to a different nursing facility, or
- Receive services in your home or other community based setting.

The continuity of care period may be longer than 30 days. *<Plan>* may extend this time frame until the health risk assessment is completed. *<Plan>* will also extend this time frame for you to have a safe and effective transition to a qualified provider within our network. Talk to your Care Coordinator if you want to learn more about these options.

If You Have Other Coverage

Medicaid is the payer of last resort. This means that if you have another insurance, are in a car accident, or if you are injured at work, your other insurance or Workers Compensation has to pay first.

We have the right and responsibility to collect payment for covered Medicaid services when Medicaid is not the first payer. We will not attempt to collect any payment directly from you. Contact Member Services if you have other insurance so that we can best coordinate your benefits. Your Care Coordinator will also work with you and your other health plan to coordinate your services.

4. Your Care Coordinator

You have a dedicated Care Coordinator who can help you to understand your covered services and how to access these services when needed. Your Care Coordinator will also help you to work with your doctor and other health care professionals (such as nurses and physical therapists), to provide a health risk assessment, and develop a care plan that considers your needs and preferences. We provide more information about the *health risk assessment* and the *care plan* below.

How Your Care Coordinator Can Help

Your Care Coordinator can:

- Answer questions about your health care
- Provide assistance with appointment scheduling
- Answer questions about getting any of the services you need. For example: behavioral health services, transportation, and long-term services and supports (LTSS)
    - Long-term services and supports (LTSS) are a variety of services and supports that help older individuals and individuals with disabilities meet their daily needs for assistance, improve the quality of their lives, and facilitate maximum independence. Examples include personal assistance services (assistance with bathing, dressing, and other basic activities of daily life and self-care), as well as support for everyday tasks such as meal preparation, laundry, and shopping. LTSS are provided over a long period of time, usually in homes and communities, but also in nursing facilities.
- Help with arranging transportation to your appointments when necessary. If you need a ride to receive a Medicaid covered service and cannot get there, non-emergency transportation is covered. Just call 1-8XX- XXX-XXXX (toll-free) or call your Care Coordinator for assistance.
- Answer questions you may have about your daily health care and living

needs including these services:

- Skilled nursing care
- Physical therapy
- Occupational therapy
- Speech therapy
- Home health care
- Personal care services
- Behavioral health services
- Services to treat addiction
- Other services that you need

[*Plans should revise this Section as necessary to list the specific services that are available and any eligibility requirements for LTSS.*]

What is a Health Risk Assessment

Within the first few weeks after you enroll with [Plan], your Care Coordinator will meet with you to ask you some questions about your health, needs and choices. Your Care Coordinator will talk with you about any medical, behavioral, physical, and social service needs that you may have. This meeting may be in-person or by phone and is known as a health risk assessment (HRA). A HRA is a complete assessment of your medical, behavioral, social, emotional, and functional status. The HRA is generally completed by your Care Coordinator within the first 30 to 60 days of your enrollment with us depending upon the type of services that you require. This health risk assessment will enable your Care Coordinator to understand your needs and help you get the care that you need.

What is a Care Plan

A care plan includes the types of health services that are needed and how you will get them. It is based on your health risk assessment. After you and your Care Coordinator complete your health risk assessment, your care team will meet with you to talk about what health and/or long term services and supports you need

and want as well as your goals and preferences. Together, you and your care team will make a personalized care plan, specific to your needs. *(This is also referred to as a person-centered care plan.)* Your care team will work with you to update your care plan when the health services you need or choose change, and at least once per year.

How to Contact Your Care Coordinator

[*Plans should include information explaining what a Care Coordinator is, how Members can contact the Care Coordinator, and how they can change their Care Coordinator if they want to.*]

CALL	<Phone number(s)> This call is free. <Days and hours of operation> [Include information on the use of alternative technologies.] We have free interpreter services for people who do not speak English.
TTY	<TTY/TDD phone number> This call is free. [*Insert if [Plan] uses a direct TTY number:* This number is for people who have hearing or speaking problems. You must have special telephone equipment to call it.] <Days and hours of operation>
FAX	[*Fax number is optional.*]
WRITE	<Mailing address>
EMAIL	[*Email address is optional.*]
WEBSITE	[*Web address is optional.*]

5. Help From Member Services

Our Member Services Staff are available to help you if you have any questions about your benefits, services or procedures or have a concern about [Plan]. Member services is available *plan provides instructions about member services including information on where to call after hours if not available 24/7/365.*

How to Contact [Plan] Member Services

CALL	<Phone number(s)> This call is free. < Daily from ? a.m. to ?:00 p.m.> [*Include hours and information on the use of alternative technologies for after hours.*] We have free interpreter services for people who do not speak English.
TTY	<TTY/TDD phone number> This call is free. [Insert if [Plan] uses a direct TTY number: This number is for people who have hearing or speaking problems. You must have special telephone equipment to call it.] <Days and hours of operation>
FAX	[*Fax number is optional.*]
WRITE	<Mailing address>
EMAIL	[*Email address is optional.*]
WEBSITE	[*Web address is optional.*]

How Member Services Can Help

Member Services can:

- Answer questions you have about [Plan]
- Answer questions you have about claims, billing or your Member ID Card
- Help you find a doctor or see if a doctor is in [Plan's] network
- Help you change your Primary Care Physician (PCP)
- Provide information on coverage decisions about your health care services

(including medications)

- A coverage decision about your health care is a decision about:
  - your benefits and covered services, or
  - the amount we will pay for your health services.

- Provide information on how you can submit an appeal about a coverage decision on your health care services (including medications). An appeal is a formal way of asking us to review a decision we made about your coverage and asking us to change it if you think we made a mistake. (See *Your Right to Appeal* in Section 15 of this handbook).
- Complaints about your health care services (including medications). You can make a complaint about us or any provider (including a non-network or network provider). A network provider is a provider who contracts and works with the health plan. You can also make a complaint about the quality of the care you received to us or to the CCC Plus Helpline at 1-844-374-9159 or TDD 1-800-817-6608. (See *Your Right to File a Complaint* in Section 15 of this handbook).

Medical Advice Line Available 24 Hours a Day, 7 Days a Week

If you are unable reach your Care Coordinator, you can reach a nurse or behavioral health professional 24 hours a day, 7 days a week to answer your questions toll-free at: 1-8XX-XXX-XXXX.

[*Plans should include information about what the Medical Advice Call Line is.*]

CALL	<Phone number(s)> This call is free. Available 24 hours a day, 7 days a week [*Include information on the use of alternative technologies.*] We have free interpreter services for people who do not speak English.

TTY	<TTY/TDD phone number> This call is free. [*Insert if [Plan] uses a direct TTY number:* This number is for people who have hearing or speaking problems. You must have special telephone equipment to call it.]

Behavioral Health Crisis Line Available 24 Hours a Day, 7 Days a Week

[*Plans should describe the Behavioral Health Crisis Line.*]

Contact [Plan] if you do not know how to get services during a crisis. We will help find a crisis provider for you. Call 1-8XX-XXX-XXXX. If you have thoughts about harming yourself or someone else, you should:

- Get help right away by calling 911.
- Go to the closest hospital for emergency care.

CALL	<Phone number(s)> This call is free. Available 24 hours a day, 7 days a week [*Include information on the use of alternative technologies.*] We have free interpreter services for people who do not speak English.
TTY	<TTY/TDD phone number> This call is free. [*Insert if [Plan] uses a direct TTY number:* This number is for people who have hearing or speaking problems. You must have special telephone equipment to call it.]

Addiction and Recovery Treatment Services (ARTS) Advice Line Available 24 Hours a Day, 7 Days a Week

If you are unable reach your Care Coordinator, you can reach a ARTS health professional 24 hours a day, 7 days a week to answer your questions at: 1-8XX-XXX-XXXX. The call is free.

[*Plans should include information about what the ARTS Medical Advice Call Line is.*]

CALL	<Phone number(s)> This call is free. Available 24 hours a day, 7 days a week [*Include information on the use of alternative technologies.*] We have free interpreter services for people who do not speak English.
TTY	<TTY/TDD phone number> This call is free. [*Insert if [Plan] uses a direct TTY number:* This number is for people who have hearing or speaking problems. You must have special telephone equipment to call it.]

If You Do Not Speak English

We can provide you with translation services. [Plan] Member Services has employees who speak your language and we are able to access interpreter services. We also have written information in many languages for our Members. Currently written materials are available in English and Spanish. If you need interpretation, please call Member Services (at no charge) at 1-800-XXX-XXXX and request to speak to an interpreter or request written materials in your language.

If You Have a Disability and Need Assistance in Understanding Information or Working with Your Care Coordinator

We provide reasonable accommodations to people with disabilities in compliance with the Americans with Disabilities Act. This includes but is not limited to accessible communications (such as a qualified sign language interpreter), braille or large print materials, etc. If you need a reasonable accommodation please call Member Services (at no charge) at [plan member services #] to ask for the help you need.

If You Have Questions About Your Medicaid Eligibility

If you have questions about your Medicaid eligibility, contact your Medicaid eligibility worker at the Department of Social Services in the city or county where you live. If you have questions about the services you get under [Plan], call Member Services at the phone number below.

6. How to Get Care and Services

How to Get Care from Your Primary Care Physician

Your Primary Care Physician

A Primary Care Physician (PCP) is a doctor selected by you who meets state requirements and is trained to give you basic medical care. You will usually see your PCP for most of your routine health care needs. Your PCP will work with you and your Care Coordinator to coordinate most of the services you get as a Member of our plan. Coordinating your services or supplies includes checking or consulting with other plan providers about your care. If you need to see a doctor other than your PCP, you may need a referral (authorization) from your PCP. You may also need to get approval in advance from your PCP before receiving certain types of covered services or supplies. In some cases, your PCP will need to get authorization (prior approval) from us. Since your PCP will provide and coordinate your medical care, you should have all of your past medical records sent to your PCP's office. Contact Member Services or your Care Coordinator with any questions you have about getting your medical records transferred to your PCP or about your care and services.

Choosing Your PCP

Plan revises as appropriate

New Members have the right to choose a PCP in our network soon after joining [Plan] by [plan inserts information on how to request one.] If you do not already have a PCP you must request one prior to the 25th day of the month before your effective enrollment date, or else [Plan] may assign you a PCP. You have the right to change your PCP at any time by calling Member Services at the number listed at the bottom of this page.

If you do not have a PCP in our network, we can help you find a highly-qualified PCP in your community. For help locating a provider you can use our on-line provider directory at: [plan website]. The provider directory includes a list of all of the doctors, clinics, hospitals, labs, specialists, long term services and supports providers, and other providers who work with [plan]. The directory also includes

information on the accommodations each provider has for individuals who have disabilities or who do not speak English. We can also provide you with a paper copy of the provider directory. You can also call Member Services at the number on the bottom of this page or call your Care Coordinator for assistance.

You may want to find a doctor:

- Who knows you and understands your health condition,
- Who is taking new patients,
- Who can speak your language, or
- Who has appropriate accommodations for people with physical or other disabilities.

If you have a disability or a chronic illness you can ask us if your specialist can be your PCP. We also contract with Federally Qualified Health Centers (FQHC) that provide primary and specialty care. Another clinic can also act as your PCP if the clinic is a network provider.

Women can also choose an OB/GYN for women's health issues. These include routine check-ups, follow-up care if there is a problem, and regular care during a pregnancy. Women do not need a PCP referral to see an OB/GYN provider in our network.

[Plan can revise to describe how Member should request a PCP or obtain assistance in finding a PCP.]

If You have Medicare, Tell us About Your PCP

If you have Medicare, you do not have to choose a PCP in [plan's] network. Simply call Member Services or your Care Coordinator to let us know the name and contact information for your PCP. We will coordinate your care with your Medicare assigned PCP.

If Your Current PCP is not in Our Network

If you do not have Medicare, you need to choose a PCP that is in [plan's] network. You can continue to see your current PCP during the continuity of care period even if they are not in the *[plan name's]* network. For Member's enrolled before April 1,

2018, the continuity of care period is 90 days. For Member's enrolled on and after April 1, 2018, the continuity of care period is 30 days. Your Care Coordinator can help you find a PCP in our network. At the end of the continuity of care period, if you do not choose a PCP in the [Plan] network, we will assign a PCP to you.

Changing Your PCP

You may call Member Services to change your PCP at any time to another PCP in our network. Also, it is possible that your PCP might leave our network. We will tell you within 15 days from when we know about this. We can help you find a new PCP.

[Plans should describe how to change a PCP and indicate when that change will take effect (e.g., on the first day of the month following the date of the request, immediately upon receipt of the request, etc.).]

Getting an Appointment with Your PCP

Your PCP will take care of most of your health care needs. Call your PCP to make an appointment. If you need care before your first appointment, call your PCP's office to ask for an earlier appointment. If you need help making an appointment, call Member Services at the number below.

Appointment Standards

You should be able to get an appointment with your PCP within the same amount of time as any other patient seen by the PCP. Expect the following times to see a provider:

- For an emergency - immediately.
- For urgent care and office visits with symptoms – within 24 hours of request.
- For routine primary care visit – within 30 calendar days.

If you are pregnant, you should be able to make an appointment to see an OB/GYN as follows:

- First trimester (first 3 months) - Within fourteen (14) calendar days of request.

- Second trimester (3 to 6 months) - Within seven (7) calendar days of request.
- Third trimester (6 to 9 months) - Within five (5) business days of request.
- High Risk Pregnancy - Within three (3) business days or immediately if an emergency exists.

If you are unable to receive an appointment within the times listed above, call Member Services at the number below and they will help you get the appointment.

Services You Can Get Without First Getting Approval From Your PCP

[***Note:*** *Insert this Section only if plans require referrals to network providers.*]

In most cases, you will need an approval from your PCP before seeing other providers. This approval is called a **referral.** You can get services like the ones listed below without first getting approval from your PCP:

- Emergency services from network providers or out-of-network providers.
- Urgently needed care from network providers.
- Family Planning Services and Supplies.
- Routine women's health care services. This includes breast exams, screening mammograms (x-rays of the breast), Pap tests, and pelvic exams as long as you get them from a network provider.
- Additionally, if you are eligible to get services from Indian health providers, you may see these providers without a referral.

[*Plans must follow Mental Health Parity and Addiction Equity Act (MHPAEA) requirements. Plans add additional bullets as appropriate.*]

How to Get Care From Network Providers

Our provider network includes access to care 24 hours a day 7 days per week and includes hospitals, doctors, specialists, urgent care facilities, nursing facilities, home and community based service providers, early intervention providers, rehabilitative therapy providers, addiction and recovery treatment services providers, home health and hospice providers, durable medical equipment providers, and other types of providers. [Plan] provides you with a choice of providers and they are

located so that you do not have to travel very far to see them. There may be special circumstances where longer travel time is required; however, that should be only on rare occasions.

Travel Time and Distance Standards

[Plan] will provide you with the services you need within the travel time and distance standards described in the table below. These standards apply for services that you travel to in order to receive care from network providers. These standards do not apply to providers who provide services to you at home. If you live in an urban area, you should not have to travel more than 30 miles or 45 minutes to receive services. If you live in a rural area, in the Roanoke/Alleghany Region, or the Southwest Region, you should not have to travel more than 60 miles or 75 minutes to receive services.

Member Travel Time & Distance Standards		
Standard	**Distance**	**Time**
Urban		
• PCP	15 Miles	30 Minutes
• Specialists and other providers	30 Miles	45 Minutes
Rural		
• PCP	30 Miles	45 Minutes
• Specialists and other providers	60 Miles	75 Minutes
Roanoke/Alleghany & Southwest Regions		
Standard	**Distance**	**Time**
Urban and Rural		
• PCPs	30 Miles	45 Minutes
• Specialists and other providers	60 Miles	75 Minutes

Accessibility

[Plan] wants to make sure that all providers and services are as accessible (including physical and geographic access) to individuals with disabilities as they are to individuals without disabilities. If you have difficulty getting an appointment with a provider, or accessing services because of a disability, contact Member Services at the telephone numbers below for assistance.

What are "Network Providers"

[Plan name's] network providers include:

- Doctors, nurses, and other health care professionals that you can go to as a Member of our plan;
- Clinics, hospitals, nursing facilities, and other places that provide health services in our plan;
- Early intervention providers, home health agencies and durable medical equipment suppliers;
- Long term services and supports (LTSS) providers including nursing facilities, hospice, adult day health care, personal care, respite care, and other LTSS providers.

Network providers have agreed to accept payment from our plan for covered services as payment in full.

What are "Network Pharmacies"

Network pharmacies are pharmacies (drug stores) that have agreed to fill prescriptions for our Members. Use the Provider and Pharmacy Directory to find the network pharmacy you want to use.

Except during an emergency, you must fill your prescriptions at one of our network pharmacies if you want our plan to help you pay for them. Call Member Services at the number at the bottom of the page for more information. Both Member Services and [Plan]'s website can give you the most up-to-date information about changes in our network pharmacies and providers. *Plan includes Member services and website information.*

What are Specialists

If you need care that your PCP cannot provide, your PCP may refer you to a specialist. Most of the specialists are in [Plan's] network. A specialist is a doctor who provides health care for a specific disease or part of the body. There are many kinds of specialists. Here are a few examples:

- *Oncologists* care for patients with cancer.

- *Cardiologists* care for patients with heart problems.
- *Orthopedists* care for patients with bone, joint, or muscle problems.

If you need to see a specialist for ongoing care, your PCP may be able to refer you for a specified number of visits or length of time (known as a standing referral). If you have a standing referral, you will not need a new referral each time you need care. If you have a disabling condition or chronic illnesses you can ask us if your specialist can be your PCP.

[*Plans should describe how Members access specialists and other network providers, including the role (if any) of the PCP in referring Members to specialists and other providers.*

If Your Provider Leaves Our Plan

A network provider you are using might leave our plan. If one of your providers does leave our plan, you have certain rights and protections that are summarized below:

- Even though our network of providers may change during the year, we must give you uninterrupted access to qualified providers.
- When possible, we will give you at least 15 days notice so that you have time to select a new provider.
- We will help you select a new qualified provider to continue managing your health care needs.
- If you are undergoing medical treatment, you have the right to ask, and we will work with you to ensure, that the medically necessary treatment you are getting is not interrupted.
- If you believe we have not replaced your previous provider with a qualified provider or that your care is not being appropriately managed, you have the right to file a complaint or request a new provider.
- If you find out one of your providers is leaving our plan, please contact your Care Coordinator so we can assist you in finding a new provider and managing your care.

[*Plans should provide contact any additional information/clarification.*]

How to Get Care from Out-of-Network Providers

[Plans should tell Members under what circumstances they may obtain services from out-of-network providers (e.g., when providers of specialized services are not available in network). Include Medicaid out-of-network requirements. Describe the process for getting authorization, including who is responsible for getting it.

If we do not have a specialist in the [Plan] network to provide the care you need, we will get you the care you need from a specialist outside of the [plan] network. We will also get you care outside of the [plan] network in any of the following circumstances:

- When [plan] has approved a doctor out of its established network;
- When emergency and family planning services are rendered to you by an out of network provider or facility;
- When you receive emergency treatment by providers not in the network;
- When the needed medical services are not available in [plan's] network;
- When [plan] cannot provide the needed specialist within the distance standard of more than 30 miles in urban areas or more than 60 miles in rural areas;
- When the type of provider needed and available in [plan's] network does not, because of moral or religious objections, furnish the service you need;
- Within the first 90 calendar days of your enrollment if you are enrolled with *<plan>* before April 1, 2018. Within the first 30 days of your enrollment if your enrollment begins with *<plan>* on or after April 1, 2018, when your provider is not part of [plan's] network but has treated you in the past; and,
- If you are in a nursing facility when you enroll with [plan], and the nursing facility is not in [plan's] network.

If your PCP or [plan] refer you to a provider outside of our network, you are not responsible for any of the costs, except for your *patient pay* towards long term services and supports. See Section 13 of this handbook for information about what

a *patient pay* is and how to know if you have one.

Care From Out-of-State Providers

[Plan] is not responsible for services you obtain outside Virginia except under the following circumstances:

- Necessary emergency or post-stabilization services;
- Where it is a general practice for those living in your locality to use medical resources in another State; and,
- The required services are medically necessary and not available in-network and within the Commonwealth of Virginia.

Network Providers Cannot Bill You Directly

Network providers must always bill [plan]. Doctors, hospitals, and other providers in our network cannot make you pay for covered services. They also cannot charge you if we pay for less than the provider charged us; this is known as "balanced billing." This is true even if we pay the provider less than the provider charged for a service. If we decide not to pay for some charges, you still do not have to pay them.

If You Receive a Bill for Covered Services

If you are billed for any of the services covered by our plan, you should not pay the bill. If you do pay the bill, [Plan] may not be able to pay you back.

Whenever you get a bill from a network provider or for services that are covered outside of the network (example emergency or family planning services) send us the bill. We will contact the provider directly and take care of the bill for covered services.

If You Receive Care From Providers Outside of the United States

Our plan does not cover any care that you get outside the United States.

7. How to Get Care for Emergencies

What is an Emergency

You are always covered for emergencies. An emergency is a sudden or unexpected illness, severe pain, accident or injury that could cause serious injury or death if it is not treated immediately.

What to do in an Emergency

Call 911 at once! You do not need to call <health plan> first. You do not need an authorization or a referral for emergency services.

Go to the closest hospital. Calling 911 will help you get to a hospital. You can use any hospital for emergency care, even if you are in another city or state. If you are helping someone else, try to stay calm.

Tell the hospital that you are a [plan] Member. Ask them to call [plan] at the number on the back of your CCC Plus ID Card.

What is a Medical Emergency

This is when a person thinks he or she must act quickly to prevent serious health problems. It includes symptoms such as severe pain or serious injury. The condition is so serious that, if it doesn't get immediate medical attention, you believe that it could cause:

- serious risk to your health; or
- serious harm to bodily functions; or
- serious dysfunction of any bodily organ or part; or
- in the case of a pregnant woman in active labor, meaning labor at a time when either of the following would occur:
    - There is not enough time to safely transfer you to another hospital before delivery, or
    - The transfer may pose a threat to your health or safety or to that of your unborn child.

What is a Behavioral Health Emergency

A behavioral health emergency is when a person thinks about or fears they might hurt themselves or hurt someone else.

Examples of Non-Emergencies

Examples of non-emergencies are: colds, sore throat, upset stomach, minor cuts and bruises, or sprained muscles. If you are not sure, call your PCP or the [Plan's] 24/7 medical advice line at: [ ].

If You Have an Emergency When Away From Home

You or a family Member may have a medical or a behavioral health emergency away from home. You may be visiting someone outside Virginia. While traveling, your symptoms may suddenly get worse. If this happens, go to the closest hospital emergency room. You can use any hospital for emergency care. Show them your [Plan] card. Tell them you are in [plan's] program.

What is Covered if You Have an Emergency

You may receive covered emergency care whenever you need it, anywhere in the United States. If you need an ambulance to get to the emergency room, our plan covers the ambulance transportation. If you have an emergency, we will talk with the doctors who give you emergency care. Those doctors will tell us when your medical emergency is complete.

Notifying [Plan] About Your Emergency

Notify your doctor and [Plan] as soon as possible about the emergency within 48 hours if you can. However, you will not have to pay for emergency services because of a delay in telling us. We need to follow up on your emergency care. Your Care Coordinator will assist you in getting the correct services in place before you are discharged to ensure that you get the best care possible. Please call *[Plan inserts instructions with contact information]*. This number is also listed on the back of [plan's] Member card.

After an Emergency

[Plan] will provide necessary follow-up care, including through out of network providers if necessary, until your physician says that your condition is stable enough for you to transfer to an in-network provider, or for you to be discharged. If you get your emergency care from out-of-network providers, we will try to get network providers to take over your care as soon as possible after your physician says you are stable. You may also need follow-up care to be sure you get better. Your follow-up care will be covered by our plan.

If You Are Hospitalized

If you are hospitalized, a family Member or a friend should contact [Plan] as soon as possible. By keeping [Plan] informed, your Care Coordinator can work with the hospital team to organize the right care and services for you before you are discharged. Your Care Coordinator will also keep your medical team including your home care services providers informed of your hospital and discharge plans.

If it Wasn't a Medical Emergency

Sometimes it can be hard to know if you have a medical emergency. You might go in for emergency care, and the doctor may say it wasn't really a medical emergency. As long as you reasonably thought your health was in serious danger, we will cover your care. However, after the doctor says it was not an emergency, we will cover your additional care only if you follow the *General Coverage Rules* described in Section 10 of this handbook.

8. How to Get Urgently Needed Care

What is Urgently Needed Care

Urgently needed care is care you get for a non-life threatening, sudden illness, injury, or condition that isn't an emergency but needs care right away. For example, you might have an existing condition that worsens and you need to have it treated right away. Other examples of urgently needed care include sprains, strains, skin rashes, infection, fever, flu, etc. In most situations, we will cover urgently needed care only if you get this care from a network provider. [Plan can keep or delete. However, if you can't get to a network provider, we will cover urgently needed care you get from an out-of-network provider.]

You can find a list of urgent care centers we work with in our Provider and Pharmacy Directory, available on our website at [ ].

[Plan can keep or delete. When you are outside the service area, you might not be able to get care from a network provider. In that case, our plan will cover urgently needed care you get from any provider.]

9. How to Get Your Prescription Drugs

This Section explains rules for getting your *outpatient prescription drugs.* These are drugs that your provider orders for you that you get from a pharmacy or drug store.

Rules for [Plan's] Outpatient Drug Coverage

Plan includes additional information as applicable.

[Plan] will usually cover your drugs as long as you follow the rules in this Section.

1. You must have a doctor or other authorized provider write your prescription. This person often is your primary care physician (PCP). It could also be another provider if your primary care physician has referred you for care.
2. You generally must use a network pharmacy to fill your prescription.
3. Your prescribed drug must be on [Plan]'s List of Covered Drugs. If it is not on the List of Covered Drugs, we may be able to cover it by giving you a service authorization.
4. Your drug must be used for a medically accepted indication. This means that the use of the drug is either approved by the Food and Drug Administration or supported by certain medical reference books.
5. If you have Medicare, most of your drugs are covered through your Medicare carrier. We cannot pay for any drugs that are covered under Medicare Part D, including copayments.
6. [Plan] can provide coverage for coinsurance and deductibles on Medicare Part A and B drugs. These include some drugs given to you while you are in a hospital or nursing facility.

Getting Your Prescriptions Filled

In most cases, [Plan] will pay for prescriptions only if they are filled at [plan's] network pharmacies. A network pharmacy is a drug store that has agreed to fill prescriptions for our Members. You may go to any of our network pharmacies.

To find a network pharmacy, you can look in the Provider and Pharmacy Directory,

visit our website, or contact Member Services at the number at the bottom of the page or your Care Coordinator.

To fill your prescription, show your Member ID Card at your network pharmacy. If you have Medicare, show your Medicare Part D and [plan] ID cards. The network pharmacy will bill [plan] for the cost of your covered prescription drug. If you do not have your Member ID Card with you when you fill your prescription, ask the pharmacy to call [Plan] to get the necessary information.

If you need help getting a prescription filled, you can contact Member Services at the number at the bottom of the page or call your Care Coordinator.

Plan includes additional instructions as applicable.

List of Covered Drugs

[Plan] has a List of Covered Drugs that are selected by [Plan] with the help of a team of doctors and pharmacists. The [plan] List of Covered Drugs also includes all of the drugs on the DMAS Preferred Drug List (PDL). The List of Covered Drugs can be found at [plan inserts plan website]. The List of Covered Drugs tells you which drugs are covered by [Plan] and also tells you if there are any rules or restrictions on any drugs, such as a limit on the amount you can get.

You can call Member Services to find out if your drugs are on the List of Covered Drugs or check on-line at [ ] or we can mail you a paper copy of the List of Covered Drugs. The List of Covered Drugs may change during the year. To get the most up-to-date List of Covered Drugs, visit [enter plan website information] or call [plan contact information including hours, etc.].

Plan provides instructions on how the member can access the list of covered drugs electronically and via paper upon request. Plan adds additional information as applicable including how individuals are notified of changes to the Drug list, especially if a medication they have been taking comes off the Plan's Drug list.

We will generally cover a drug on [plan's] List of Covered Drugs as long as you follow the rules explained in this Section. You can also get drugs that are not on the list when medically necessary. Your physician may have to obtain a service authorization from us in order for you to receive some drugs.

Limits for Coverage of Some Drugs

For certain prescription drugs, special rules limit how and when we cover them. In general, our rules encourage you to get a drug that works for your medical condition and that is safe and effective, and cost effective.

If there is a special rule for your drug, it usually means that you or your provider will have to take extra steps for us to cover the drug. For example, your provider may need to request a service authorization for you to receive the drug. We may or may not agree to approve the request without taking extra steps. Refer to *Service Authorization and Benefit Determination and Service Authorizations and Continuity of Care* in Section 14 of this handbook.

If *[Plan]* is new for you, you can keep getting your authorized drugs for the duration of the authorization or during the continuity of care period after you first enroll, whichever is sooner. For Member's enrolled before April 1, 2018, the continuity of care period is 90 days. For Member's enrolled on and after April 1, 2018, the continuity of care period is 30 days. Refer to *Continuity of Care Period* in Section 3 of this handbook.

If we deny or limit coverage for a drug, and you disagree with our decision, you have the right to appeal our decision. Refer to *Your Right to Appeal* in Section 15 of this handbook. If you have any concerns, contact your Care Coordinator. Your Care Coordinator will work with you and your PCP to make sure that you receive the drugs that work best for you.

Getting Approval in Advance

For some drugs, you or your doctor must get a service authorization approval from [Plan] before you fill your prescription. If you don't get approval, [Plan] may not cover the drug.

Trying a Different Drug First

We may require that you first try one (usually less-expensive) drug (before we will cover another (usually more-expensive) drug for the same medical condition. For example, if Drug A and Drug B treat the same medical condition, the plan may require you to try Drug A first. If Drug A does not work for you, then we will cover

Drug B. This is called step therapy.

Quantity Limits

For some drugs, we may limit the amount of the drug you can have. This is called a quantity limit. For example, the plan might limit how much of a drug you can get each time you fill your prescription.

To find out if any of the rules above apply to a drug your physician has prescribed, check the List of Covered Drugs. For the most up-to-date information, call Member Services or check our website at *[Plan inserts].*

Emergency Supply

There may be an instance where your medication requires a service authorization, and your prescribing physician cannot readily provide authorization information to us, for example over the weekend or on a holiday. If your pharmacist believes that your health would be compromised without the benefit of the drug, we may authorize a 72-hour emergency supply of the prescribed medication. This process provides you with a short-term supply of the medications you need and gives time for your physician to submit a service authorization request for the prescribed medication.

Non Covered Drugs

By law the types of drugs listed below are not covered by Medicare or Medicaid:

- Drugs used to promote fertility;
- Drugs used for cosmetic purposes or to promote hair growth;
- Drugs used for the treatment of sexual or erectile dysfunction, such as Viagra®, Cialis®, Levitra®, and Caverject®, unless such agents are used to treat a condition other than sexual or erectile dysfunction, for which the agents have been approved by the FDA;
- Drugs used for treatment of anorexia, weight loss, or weight gain;
- All DESI (Drug Efficacy Study Implementation) drugs as defined by the FDA to be less than effective, including prescriptions that include a DESI drug;

- Drugs that have been recalled;
- Experimental drugs or non-FDA-approved drugs; and,
- Any drugs marketed by a manufacturer who does not participate in the Virginia Medicaid Drug Rebate program.

Changing Pharmacies

If you need to change pharmacies and need a refill of a prescription, you can ask your pharmacy to transfer the prescription to the new pharmacy. If you need help changing your network pharmacy, you can contact Member Services at the number at the bottom of the page or your Care Coordinator.

If the pharmacy you use leaves [plan's] network, you will have to find a new network pharmacy. To find a new network pharmacy, you can look in the Provider and Pharmacy Directory, visit our website, or contact Member Services at the number at the bottom of the page or your Care Coordinator. Member Services can tell you if there is a network pharmacy nearby.

What if You Need a Specialized Pharmacy

Sometimes prescriptions must be filled at a specialized pharmacy. Specialized pharmacies include pharmacies that supply drugs for home infusion therapy or residents of a long-term care facility, such as a nursing facility.

Usually, nursing facilities have their own pharmacies. If you are a resident of a nursing facility, we must make sure you can get the drugs you need at the nursing facility's pharmacy. If you have any problems getting your drug benefits in a nursing facility, please contact your Care Coordinator or Member Services at the number at the bottom of the page.

Can You Use Mail-Order Services to Get Your Drugs

Plan fills in specifics as applicable

Can You Get a Long-Term Supply of Drugs

Plan fills in as applicable

Can You Use a Pharmacy That is Not in [Plan]'s Network

Plan fills in as applicable

What is the Patient Utilization Management and Safety (PUMS) Program

Some Members who require additional monitoring may be enrolled in the Patient Utilization Management and Safety (PUMS) program. The PUMS program is required by DMAS and helps make sure your drugs and health services work together in a way that won't harm your health. As part of this program, we may check the Prescription Monitoring Program (PMP) tool that the Virginia Department of Health Professions maintains to review your drugs. This tool uses an electronic system to monitor the dispensing of controlled substance prescription drugs.

If you are chosen for PUMS, you may be restricted to or locked into only using one pharmacy or only going to one provider to get certain types of medicines. We will send you a letter to let you know how PUMS works. The lock-in period is for 12 months. At the end of the lock in period, we'll check in with you to see if you should continue the program. If you are placed in PUMS and don't think you should be in the program, you can appeal. You must appeal to us within 60 days of when you get the letter saying that you have been put into PUMS. You can also request a State Fair Hearing. Refer to *Appeals, State Fair Hearings, and Complaints* in Section 15 of this handbook.

If you're in the PUMS program, you can get prescriptions after hours if your selected pharmacy doesn't have 24 hour access. You'll also be able to pick a PCP, pharmacy or other provider where you want to be locked in. If you don't select providers for lock in within 15 days, we'll choose them for you.

Members who are enrolled in PUMS will receive a letter from [plan] that provides additional information on PUMS including all of the following information:

- A brief explanation of the PUMS program;
- A statement explaining the reason for placement in the PUMS program;

- Information on how to appeal to [plan] if placed in the PUMS program;
- information regarding how request a State Fair Hearing after first exhausting the [plan's] appeals process;
- Information on any special rules to follow for obtaining services, including for emergency or after hours services; and
- Information on how to choose a PUMS provider.

Contact Member Services at the number below or your Care Coordinator if you have any questions on PUMS.

10. How to Access Your CCC Plus Benefits

CCC Plus Benefits

As a [Plan] member, you have a variety of health care benefits and services available to you. You will receive most of your services through the [plan], but may receive some through DMAS or a DMAS Contractor.

- Services provided through [Plan] are described in this Section 10 of the handbook.
- Services covered by DMAS or a DMAS Contractor are described in Section 11 of this handbook.
- Services that are not covered through [Plan] or DMAS are described in Section 12 of this handbook.

Services you receive through [Plan] or through DMAS will not require you to pay any costs other than your "patient pay" towards long term services and supports. Section 13 of this handbook provides information on what a "patient pay" is and how you know if you have one.

General Coverage Rules

To receive coverage for services you must meet the general coverage requirements described below.

1. Your services (including medical care, services, supplies, equipment, and drugs) must be medically necessary. Medically necessary generally means you need the service or supplies to prevent, diagnose, or treat a medical condition or its symptoms based on accepted standards of medical practice.
2. In most cases, you must get your care from a network provider. A network provider is a provider who works with [Plan]. In most cases, [Plan] will not pay for care you get from an out- of-network provider unless the service is authorized by [plan]. Section 6 has more information about using network and out-of-network providers, including *Services You Can Get Without First Getting Approval From Your PCP.*

3. Some of your benefits are covered only if your doctor or other network provider gets approval from us first. This is called a service authorization. Section 14 includes more information about service authorizations.
4. If *[Plan]* is new for you, you can keep seeing the doctors you go to now during the continuity of care period. You can also keep getting your authorized services for the duration of the authorization or during the continuity of care period after you first enroll, whichever is sooner. For Member's enrolled before April 1, 2018, the continuity of care period is 90 days. For Member's enrolled on and after April 1, 2018, the continuity of care period is 30 days. Also see *Continuity of Care Period* in Section 3 of this handbook.

Benefits Covered Through [Plan]

[Plan] covers all of the following services for you when they are medically necessary. If you have Medicare or another insurance plan, we will coordinate these services with your Medicare or other insurance plan. Refer to Section 11 of this handbook for *Services Covered Through the DMAS Medicaid Fee-For-Service Program*.

- Regular medical care, including office visits with your PCP, referrals to specialists, exams, etc. *See Section 6 of this handbook for more information about PCP services.*
- Preventive care, including regular check-ups, screenings, and well-baby/child visits. *See Section 6 of this handbook for more information about PCP services.*
- Addiction and Recovery Treatment Services (ARTS), including inpatient, outpatient, community based, medication assisted treatment, peer services, and case management. Services may require authorization. *Additional information about ARTS services is provided below in this Section of the handbook.*
- Adult day health Care services (see CCC Plus Waiver)
- Behavioral health services, including c*ommunity mental health rehabilitation*

services, inpatient and outpatient individual, family, and group psychotherapy services are covered. *(Community Mental Health Rehabilitation Services are covered through <Plan> beginning on January 1, 2018, including:*

- Mental Health Case Management
- Therapeutic Day Treatment (TDT) for Children
- Day Treatment/ Partial Hospitalization for Adults
- Crisis Intervention and Stabilization
- Intensive Community Treatment
- Mental Health Skill-building Services (MHSS)
- Intensive In-Home
- Psychosocial Rehabilitation
- Behavioral Therapy
- Mental Health Peer Supports

- Care coordination services, including assistance connecting to CCC Plus covered services and to housing, food, and community resources. *See Section 4 of this handbook for more information about your Care Coordinator.*
- Clinic services, including renal dialysis.
- CCC Plus Home and Community Based Waiver services, (formerly known as the EDCD and Technology Assisted Waivers), including: adult day health care, assistive technology, environmental modifications, personal care services, personal emergency response systems (PERS), private duty nursing services, respite services, services facilitation, transition services. *Additional information about CCC Plus Waiver services is provided later in this Section. Section 11 of this handbook provides information about DD Waiver Services.*
- Colorectal cancer screening.
- Court ordered services.
- Durable medical equipment (DME) and supplies including medically necessary respiratory, oxygen, and ventilator equipment and supplies, wheelchairs and accessories, hospital beds, diabetic equipment and supplies, incontinence products, assistive technology, communication devices, and

rehabilitative equipment and devices and other necessary equipment and supplies.

- Early and Periodic Screening Diagnostic and Treatment services (EPSDT) for children under age 21. *Additional information about EPSDT services is provided later in this Section of the handbook.*
- Early Intervention services for children from birth to age 3. *Additional information about early intervention services is provided later in this Section of the handbook.*
- Electroconvulsive therapy (ECT).
- Emergency custody orders (ECO).
- Emergency services including emergency transportation services (ambulance, etc.).
- Emergency and post stabilization services. *Additional information about emergency and post stabilization services is provided in Section 7 of this handbook.*
- End stage renal disease services.
- Eye examinations.
- Family planning services, including services, devices, drugs (including long acting reversible contraception) and supplies for the delay or prevention of pregnancy. You are free to choose your method for family planning including through providers who are in/out of [Plan's] network. [Plan] does not require you to obtain a service authorization or a PCP referral for family planning services.
- Glucose test strips.
- Hearing (audiology) services.
- Home health services.
- Hospice services.
- Hospital care – inpatient/outpatient.

- Human Immunodeficiency Virus (HIV) testing and treatment counseling.
- Immunizations.
- Inpatient psychiatric hospital services.
- Laboratory, Radiology and Anesthesia Services.
- Lead investigations.
- Mammograms.
- Maternity care - includes: pregnancy care, doctors/certified nurse-midwife services. Additional information about maternity care is provided in Section 6 of this handbook.
- Nursing facility - includes skilled, specialized care, long stay hospital, and custodial care. *Additional information about nursing facility services is provided later in this Section of the handbook.*
- Nurse Midwife Services through a Certified Nurse Midwife provider.
- Organ transplants.
- Orthotics, including braces, splints and supports - for children under 21, or adults through an intensive rehabilitation program.
- Outpatient hospital services.
- Pap smears.
- Personal care or personal assistance services (through EPSDT or through the CCC Plus Waiver).
- Physician's services or provider services, including doctor's office visits.
- Physical, occupational, and speech therapies.
- Podiatry services (foot care).
- Prenatal and maternal services.
- Prescription drugs. *See Section 9 of this handbook for more information on pharmacy services.*
- Private duty nursing services (through EPSDT and through the CCC Plus HCBS

Waiver).

- Prostate specific antigen (PSA) and digital rectal exams.
- Prosthetic devices including arms, legs and their supportive attachments, breasts, and eye prostheses).
- Psychiatric or psychological services.
- Radiology services.
- Reconstructive breast surgery.
- Renal (kidney) dialysis services.
- Rehabilitation services – inpatient and outpatient (including physical therapy, occupational therapy, speech pathology and audiology services).
- Second opinion services from a qualified health care provider within the network or we will arrange for you to obtain one at no cost outside the network. The doctor providing the second opinion must not be in the same practice as the first doctor. Out of network referrals may be approved when no participating provider is accessible or when no participating provider can meet your individual needs.
- Surgery services when medically necessary and approved by [plan.]
- Telemedicine services.
- Temporary detention orders (TDO).
- Tobacco Cessation Services for pregnant women, children, and adolescents under age 21.
- Transportation services, including emergency and non-emergency (air travel, ground ambulance, stretcher vans, wheelchair vans, public bus, volunteer/ registered drivers, taxi cabs). [Plan] will also provide transportation to/from most "carved-out" and enhanced services. *Additional information about transportation services is provided later in this Section of the handbook. Transportation services for DD Waiver services are covered through DMAS, as described in Section 11 of this handbook.*

- Vision services.
- Well Visits *(Plans include specifics).*
- Abortion services- coverage is only available in cases where there would be a substantial danger to the life of the mother.

Extra Benefits We Provide That are not Covered by Medicaid

As a member of [Plan] you have access to services that are not generally covered through Medicaid fee-for-service. These are known as "enhanced benefits." We provide the following enhanced benefits:

Plan provides information on enhanced benefits.

How to Access Early and Periodic Screening, Diagnostic, and Treatment Services

What is EPSDT

The Early and Periodic Screening, Diagnostic and Treatment (EPSDT) program is a federally mandated Medicaid benefit that provides comprehensive and preventive health care services for children under age 21. If you have a child that is under age 21, EPSDT provides appropriate preventive, dental, behavioral health, developmental, and specialty services. It includes coverage for immunizations, well child visits, lead investigations, private duty nursing, personal care, and other services and therapies that treat or make a condition better. It will also cover services that keep your child's condition from getting worse. EPSDT can provide coverage for medically necessary services even if these are not normally covered by Medicaid.

Getting EPSDT Services

[Plan] provides most of the Medicaid EPSDT covered services. However, some EPSDT services, like pediatric dental care, are not covered by [Plan]. For any services not covered by [Plan], you can get these through the Medicaid fee-for-service program. Additional information about services provided through Medicaid fee-for-service is provided in Section 11 of this handbook.

[*Plans should provide applicable information about getting EPSDT services, including service authorization requirements.*]

Getting Early Intervention Services

If you have a baby under the age of three, and you believe that he or she is not learning or developing like other babies and toddlers, your child may qualify for early intervention services. Early intervention includes services such as speech therapy, physical therapy, occupational therapy, service coordination, and developmental services to help families support their child's learning and development during everyday activities and routines. Services are generally provided in your home.

The first step is meeting with the local *Infant and Toddler Connection* program in your community to see if your child is eligible. A child from birth to age three is eligible if he or she has (i) a 25% developmental delay in one or more areas of development; (ii) atypical development; or, (iii) a diagnosed physical or mental condition that has a high probability of resulting in a developmental delay.

For more information, call your Care Coordinator. Your Care Coordinator can help. If your child is enrolled in [plan] we provide coverage for early intervention services. Your Care Coordinator will work closely with you and the *Infant and Toddler Connection* program to help you access these services and any other services that your child may need. Information is also available at www.infantva.org or by calling 1-800-234-1448.

How to Access Behavioral Health Services

Behavioral health services offer a wide range of treatment options for individuals with a mental health or substance use disorder. Many individuals struggle with mental health conditions such as depression, anxiety, or other mental health issues as well as using substances at some time in their lives. These behavioral health services aim to help individuals live in the community and maintain the most independent and satisfying lifestyle possible. Services range from outpatient counseling to hospital care, including day treatment and crisis services. These services can be provided in your home or in the community, for a short or long

timeframe, and all are performed by qualified individuals and organizations.

Contact your Care Coordinator if you are having trouble coping with thoughts and feelings. Your Care Coordinator will help you make an appointment to speak with a behavioral healthcare professional.

Some Behavioral Health services are covered for you through Magellan, the DMAS Behavioral Health Services Administrator (BHSA). Your Care Coordinator will work closely with the BHSA to coordinate the services you need, including those that are provided through the BHSA.

[*Plans should provide applicable information about getting behavioral health services, including service authorization requirements. Plans must follow Mental Health Parity and Addiction Equity Act (MHPAEA) requirements.]*

How to Access Addiction and Recovery Treatment Services (ARTS)

[Plan] offers a variety of services that help individuals who are struggling with using substances, including drugs and alcohol. Addiction is a medical illness, just like diabetes, that many people deal with and can benefit from treatment no matter how bad the problem may seem. If you need treatment for addiction, we provide coverage for services that can help you. These services include settings in inpatient, outpatient, residential, and community-based treatment. Medication assisted treatment options are also available if you are dealing with using prescription or non-prescription drugs. Other options that are helpful include peer services (someone who has experience similar issues and in recovery), as well as case management services. Talk to your PCP or call your Care Coordinator to determine the best option for you and how to get help in addiction and recovery treatment services. To find an ARTS provider, you can look in the Provider and Pharmacy Directory, visit our website, call your Care Coordinator, or contact Member Services at one of the numbers below.

[*Plans should provide applicable information about getting ARTS services, including service authorization requirements. Plans must follow Mental Health Parity and Addiction Equity Act (MHPAEA) requirements.*]

How to Access Long-Term Services and Supports (LTSS)

[Plan] provides coverage for long-term services and supports (LTSS) including a variety of services and supports that help older individuals and individuals with disabilities meet their daily needs and maintain maximum independence. LTSS can provide assistance that helps you live in your own home or other setting of your choice and improves your quality life. Examples services include personal assistance services (assistance with bathing, dressing, and other basic activities of daily life and self-care), as well as support for everyday tasks such as laundry, shopping, and transportation. LTSS are provided over a long period of time, usually in homes and communities (through a home and community based waiver), but also in nursing facilities. If you need help with these services, please call your Care Coordinator who will help you in the process to find out if you meet the Virginia eligibility requirements for these services. Also see the Sections: *Commonwealth Coordinated Care Plus Waiver*, *Nursing Facility Services*, and *How to Get Services if you are in a DD Waiver* described later in this Section of the handbook.

Commonwealth Coordinated Care Plus Waiver

Some Members may qualify for home and community based care waiver services through the Commonwealth Coordinated Care Plus Waiver (formerly known as the Elderly or Disabled with Consumer Direction and Technology Assistance Waivers).

The Commonwealth Coordinated Care Plus (CCC Plus) Waiver is meant to allow a Member who qualifies for nursing facility level of care to remain in the community with help to meet their daily needs. If determined eligible for CCC Plus Waiver services, you may choose how to receive personal assistance services. You have the option to receive services through an agency (known as agency directed) or you may choose to serve as the employer for a personal assistance attendant (known as self-directed.) Information on self-directed care is described in more detail below, in this Section of the handbook.

CCC Plus Waiver Services may include:

- Private duty nursing services (agency directed)
- Personal care (agency or self-directed)

- Respite care (agency or self-directed)
- Adult day health care
- Personal emergency response system (with or without medication monitoring)
- Transition coordination/services for Members transitioning to the community from a nursing facility or long stay hospital
- Assistive technology
- Environmental modifications

[Individuals enrolled in a DD Waiver should see *How to Get Services if you are in a DD Waiver* described later in this Section.]

How to Self-Direct Your Care

Self-directed care refers to personal care and respite care services provided under the CCC Plus Waiver. These are services in which the Member or their family/caregiver is responsible for hiring, training, supervising, and firing of their attendant. You will receive financial management support in your role as the employer to assist with enrolling your providers, conducting provider background checks, and paying your providers.

If you have been approved to receive CCC Plus Waiver services and would like more information on the self-directed model of care, please contact your Care Coordinator who will assist you with these services.

Your Care Coordinator will also monitor your care as long as you are receiving CCC Plus Waiver services to make sure the care provided is meeting your daily needs.

[*Plans should provide applicable information about getting CCC Plus Waiver services, including service authorization requirements.*]

Nursing Facility Services

If you are determined to meet the coverage criteria for nursing facility care, and choose to receive your long term services and supports in a nursing facility, [plan] will provide coverage for nursing facility care. If you have Medicare, [Plan] will

provide coverage for nursing facility care after you exhaust your Medicare covered days in the nursing facility, typically referred to as skilled nursing care.

If you are in a nursing facility, you may be able to move from your nursing facility to your own home and receive home and community based services if you want to. If you are interested in moving out of the nursing facility into the community, talk with your Care Coordinator. Your Care Coordinator is available to work with you, your family, and the discharge planner at the nursing facility if you are interested in moving from the nursing facility to a home or community setting.

If you choose not to leave the nursing facility, you can remain in the nursing facility for as long as you are determined to meet the coverage criteria for nursing facility care.

[*Plans should provide applicable information about getting nursing facility services, including service authorization requirements.*]

Screening for Long Term Services and Supports

Before you can receive long term services and supports (LTSS) you must be screened by a community based or hospital screening team. A screening is used to determine if you meet the level of care criteria for LTSS. Contact your Care Coordinator to find out more about the screening process in order to receive LTSS.

Freedom of Choice

If you are approved to receive long term services and supports, you have the right to receive care in the setting of your choice:

- In your home, or
- In another place in the community, or
- In a nursing facility.

You can choose the doctors and health professionals for your care from our network. If you prefer to receive services in your home under the CCC Plus Waiver, for example, you can choose to directly hire your own personal care attendant(s), known as self-directed care. Another option you have is to choose a personal care agency in our network, where the agency will hire, train, and supervise personal

assistance workers on your behalf, known as agency direction. You also have the option to receive services in a nursing facility from our network of nursing facility providers.

How to Get Services if You are in a Developmental Disability Waiver

If you are enrolled in one of the DD waivers, you will be enrolled in CCC Plus for your *non-waiver services*. The DD waivers include:

- The Building Independence (BI) Waiver,
- The Community Living (CL) Waiver, and
- The Family and Individual Supports (FIS) Waiver.

[Plan] will only provide coverage for your *non-waiver services*. Non-waiver services include all of the services listed in Section 10, *Benefits Covered through [Plan].* *Exception:* If you are enrolled in one of the DD Waivers, you would not also be eligible to receive services through the CCC Plus Waiver.

DD Waiver services, DD and ID targeted case management services, and transportation to/from DD waiver services, will be paid through Medicaid fee-for-service as "carved-out" services. The carve-out also includes any DD waiver services that are covered through EPSDT for DD waiver enrolled individuals under the age of 21.

If you have a developmental disability and need DD waiver services, you will need to have a diagnostic and functional eligibility assessment completed by your local Community Services Board (CSB). All individuals enrolled in one of the DD waivers follow the same process to qualify for and access BI, CL and FIS services and supports. Services are based on assessed needs and are included in your person-centered individualized service plan.

The DD waivers have a wait list. Individuals who are on the DD waiver waiting list may qualify to be enrolled in the CCC Plus Waiver until a BI, CL or FIS DD waiver slot becomes available and is assigned to the individual. The DD waiver waiting list is maintained by the CSBs in your community. For more information on the DD

Waivers and the services that are covered under each DD Waiver, visit the Department of Behavioral Health and Developmental Services (DBHDS) website at: http://www.mylifemycommunityvirginia.org/ or call 1-844-603-9248. Your Care Coordinator will work closely with you and your DD or ID case manager to help you get all of your covered services. Contact your Care Coordinator if you have any questions or concerns.

How to Get Non-Emergency Transportation Services

Non-Emergency Transportation Services Covered by [Plan]

Non-Emergency transportation services are covered by [Plan] for covered services, carved out services, and enhanced benefits. Exception: If you are enrolled in a DD Waiver, [plan] provides coverage for your transportation to/from your non-waiver services. (Refer to *Transportation to/from DD Waiver Services* below.)

Transportation may be provided if you have no other means of transportation and need to go to a physician or a health care facility for a covered service. For urgent or non-emergency medical appointments, call the reservation line at 1-8XX-XXX-XXXX. If you are having problems getting transportation to your appointments, call [Plan Transportation Contractor] at [phone number] or Member Services at the number below. Member services is here to help.

In case of a life-threatening emergency, call 911. Refer to *How to Get Care for Emergencies* in Chapter 7 of this handbook.

[*Plans should provide applicable information about getting transportation services including advance notice for routine reservations and contact information.*]

Transportation to and From DD Waiver Services

If you are enrolled in a DD Waiver, [plan] provides coverage for your transportation to and from your *non-waiver services.* (Call the number ***above*** for transportation to your ***non-waiver services***.)

Transportation to your DD Waiver services is covered by the DMAS Transportation Contractor. You can find out more about how to access transportation services through the DMAS Transportation Contractor on the website at:

http://www.dmas.virginia.gov/Content_pgs/trn-info.aspx or by calling the Transportation Contractor. Transportation for routine appointments are taken Monday through Friday between the hours of 6:00 AM to 8:00 PM. The DMAS Transportation Contractor is available 24 hours a day, 7 days a week to schedule urgent reservations, at: 1-866-386-8331 or TTY 1-866-288-3133 or 711 to reach a relay operator.

If you have problems getting transportation to your DD waiver services, you may call your DD or ID Waiver case manager or the DMAS Transportation Contractor at the number above. You can also call your Care Coordinator. Your Care Coordinator will work closely with you and your DD or ID Waiver case manager to help get the services that you need. Member Services is also available to help at the number below.

11. Services Covered Through the DMAS Medicaid Fee-For-Service Program

Carved-Out Services

The Department of Medical Assistance Services will provide you with coverage for the services listed below. These services are known as "carved-out services." Your provider bills fee-for-service Medicaid (or a DMAS Contractor) for these services.

Your Care Coordinator can also help you to access these services if you need them.

-
- Dental Services are provided through the *Smiles For Children* program. DMAS has contracted with DentaQuest to coordinate the delivery of all Medicaid dental services. The name of the program is *Smiles For Children*. *Smiles for Children* provides coverage for the following populations and services:
    - For children under age 21: diagnostic, preventive, restorative/surgical procedures, as well as orthodontia services.
    - For pregnant women: x-rays and examinations, cleanings, fillings, root canals, gum related treatment, crowns, bridges, partials, and dentures, tooth extractions and other oral surgeries, and other appropriate general services. Orthodontic treatment is not included. The dental coverage ends 60 days after the baby is born.
    - For adults age 21 and over, coverage is only available for limited medically necessary oral surgery services. Routine dental services are not covered for adults other than as described above for pregnant women.

  If you have any questions about your dental coverage through *Smiles for Children*, you can reach DentaQuest Member Services at 1-888-912-3456, Monday through Friday, 8:00 AM - 6:00 PM EST. The TTY/TDD number is 1-800-466- 7566. Additional information is provided at: http://www.dmas.virginia.gov/Content_pgs/dnt-enrollees.aspx.

[Plan] provides coverage for non-emergency transportation for any dental services covered through *Smiles for Children*, as described above. Contact Member Services at the number below if you need assistance.

Plan should revise to include appropriate information if adult dental is provided through the plan as an enhanced benefit.

- Developmental Disability (DD) Waiver Services, including Case Management for DD Waiver Services, are covered through DBHDS. The carve-out includes any DD Waiver services that are covered through EPSDT for DD waiver enrolled individuals and transportation to/from DD Waiver services. Also see *How to Get Services if you are in a Developmental Disability Waiver* in Section 10 of this handbook.
- School health services including certain medical, mental health, hearing, or rehabilitation therapy services that are arranged by your child's school. The law requires schools to provide students with disabilities a free and appropriate public education, including special education and related services according to each student's *Individualized Education Program (IEP).* While schools are financially responsible for educational services, in the case of a Medicaid-eligible student, part of the costs of the services identified in the student's IEP may be covered by Medicaid. When covered by Medicaid, school health services are paid by DMAS. Contact your child's school administrator if you have questions about school health services.
- Therapeutic Group Home Services for children and adolescents younger than the age of 21. This is a place where children and adolescents live while they get treatment. Children under this level of care have serious mental health concerns. These services provide supervision and behavioral health care toward therapeutic goals. These services also help the Member and their family work towards discharge to the Member's home. Additional information about Therapeutic Group Home Services is available on the Magellan website at: http://www.magellanofvirginia.com or by calling: 1-800-424-4046 TDD: 1-800-424-4048 or TTY: 711. You can also call your Care Coordinator for assistance.

Services That Will End Your CCC Plus Enrollment

If you receive any of the services below, your enrollment with [Plan] will end. You will receive these services through DMAS or a DMAS Contractor.

- PACE (Program of All Inclusive Care for the Elderly). *For more information about PACE, talk to your Care Coordinator or visit:* http://www.dmas.virginia.gov/Content_pgs/ltc-pace.aspx.
- Medicaid Money Follows the Person (MFP) Program. *For more information about MFP, talk to your Care Coordinator or visit:* http://www.dmas.virginia.gov/Content_pgs/ltc-mfp.aspx.
- Alzheimer's Assisted Living Waiver. *For more information about the Alzheimer's waiver; talk to your Care Coordinator or visit: http://www.dmas.virginia.gov/Content_pgs/ltc-wvr_aal.aspx.*
- You reside in an Intermediate Care Facility for Individuals with Intellectual and Developmental Disabilities (ICF/IID).
- You are receiving care in a Psychiatric Residential Treatment Facility (children under 21). Additional information about Psychiatric Residential Treatment Facility Services is available on the Magellan website at: http://www.magellanofvirginia.com or by calling: 1-800-424-4046 TDD: 1-800-424-4048 or TTY: 711. You can also call your Care Coordinator for assistance.
- You reside in a Veteran's Nursing Facility.
- You reside in one of these State long term care facilities: Piedmont, Catawba, Hiram Davis, or Hancock.

12. Services Not Covered by CCC Plus

The following services are not covered by Medicaid or [Plan]. If you receive any of the following non-covered services, you will be responsible for the cost of these services.

(Plans revise if any of these are covered as enhanced benefits through your plan)

- Acupuncture
- Administrative expenses, such as completion of forms and copying records
- Artificial insemination, in-vitro fertilization, or other services to promote fertility
- Certain drugs not proven effective
- Certain experimental surgical and diagnostic procedures
- Chiropractic services
- Cosmetic treatment or surgery
- Daycare, including companion services for the elderly (except in some home- and community-based service waivers)
- Dentures or routine dental services for Members age 21 and over
- Drugs prescribed to treat hair loss or to bleach skin
- Eyeglasses or their repair for Members age 21 or older
- Immunizations if you are age 21 or older (except for flu and pneumonia for those at risk and as authorized by [Plan])
- Medical care other than emergency services, urgent services, [plan keeps or deletes urgent care services], or family planning services, received from providers outside of the network unless authorized by [Plan]
- Personal care services (except through some home and community-based service waivers or under EPSDT)
- Prescription drugs covered under Medicare Part D, including the Medicare copayment.

- Private duty nursing (except through some home and community-based service waivers or under EPSDT)
- Routine dental care if you are age 21 or older
- Weight loss clinic programs unless authorized
- Care outside of the United States

[Plan should revise/add if any of these services are covered as enhanced benefits or when authorized through [Plan]]

If You Receive Non-Covered Services

We cover your services when you are enrolled with our plan and:

- Services are medically necessary, and
- Services are listed as *Benefits Covered Through [Plan]* in Section 10 of this handbook, and
- You receive services by following plan rules.

If you get services that aren't covered by our plan or covered through DMAS, you must pay the full cost yourself. If you are not sure and want to know if we will pay for any medical service or care, you have the right to ask us. You can call Member services or your Care Coordinator to find out more about services and how to obtain them. You also have the right to ask for this in writing. If we say we will not pay for your services, you have the right to appeal our decision.

Section 15 provides instructions for how to appeal [Plan]'s coverage decisions. You may also call Member Services to learn more about your appeal rights or to obtain assistance in filing an appeal.

13. Member Cost Sharing

There are no copayments for services covered through the CCC Plus Program. This includes services that are covered through [Plan] or services that are carved-out of the CCC Plus contract. The services provided through [Plan] or through DMAS will not require you to pay any costs other than your patient pay towards long term services and supports. See the *Member Patient Pay* Section below.

CCC Plus does not allow providers to charge you for covered services. [Plan] pays providers directly, and we protect you from any charges. This is true even if we pay the provider less than the provider charges for a service. If you receive a bill for a covered service, contact Member services and they will help you.

If you get services that aren't covered by our plan or covered through DMAS, you must pay the full cost yourself. If you are not sure and want to know if we will pay for any medical service or care, you have the right to ask us. You can call Member services or your Care Coordinator to find out more about services and how to obtain them. You also have the right to ask for this in writing. If we say we will not pay for your services, you have the right to appeal our decision. See Section 12 of this handbook for a list of non-covered services.

Member Patient Pay Towards Long Term Services and Supports

You may have a *patient pay* responsibility towards the cost of nursing facility care and home and community based waiver services. A patient pay is required to be calculated for all Members who get nursing facility or home and community based waiver services. When your income exceeds a certain amount, you must contribute toward the cost of your long term services and supports. If you have a patient pay amount, you will receive notice from your local Department of Social Services (DSS) of your patient pay responsibility. DMAS also shares your patient pay amount with [Plan] if you are required to pay towards the cost of your long term services and supports. If you have questions about your patient pay amount, contact your Medicaid eligibility worker at the local Department of Social Services.

Medicare Members and Part D Drugs

If you have Medicare, you get your prescription medicines from Medicare Part D; not from the CCC Plus Medicaid program. CCC Plus does not pay the copayment for the medicines that Medicare Part D covers.

Plan revises if payment of Part D copays are covered as an enhanced benefit under the plan.

14. Service Authorization and Benefit Determination

Service Authorization

There are some treatments, services, and drugs that you need to get approval for before you receive them or in order to be able to continue receiving them. This is called a service authorization. You, your doctor, or someone you trust can ask for a service authorization.

If the services you require are covered through Medicare then a service authorization from [Plan] is not required. If you have questions regarding what services are covered under Medicare, please contact your Medicare health plan. You can also contact your [Plan] Care Coordinator.

A service authorization helps to determine if certain services or procedures are medically needed and covered by the plan. Decisions are based on what is right for each member and on the type of care and services that are needed.

We look at standards of care based on:

- Medical policies
- National clinical guidelines
- Medicaid guidelines
- Your health benefits

[Plan] does not reward employees, consultants, or other providers to:

- Deny care or services that you need
- Support decisions that approve less than what you need
- Say you don't have coverage

Service authorizations are not required for early intervention services, emergency care, family planning services (including long acting reversible contraceptives), preventive services, and basic prenatal care.

The following treatments and services must be authorized before you get them:

[Plan enters all services that require service authorization, including those that

require an authorization beyond a certain limit].

To find out more about how to request approval for these treatments or services you can contact Member Services at the number below or call your Care Coordinator.

Service Authorizations and Continuity of Care

If you are new to *[Plan]* we will honor any service authorization approvals made by DMAS or issued by another CCC Plus plan during the continuity of care period or until the authorization ends if that is sooner. For Member's enrolled before April 1, 2018, the continuity of care period is 90 days. For Member's enrolled on and after April 1, 2018, the continuity of care period is 30 days. Refer to *Continuity of Care Period* in Section 3 of this handbook.

How to Submit a Service Authorization Request

[Plan enters other instructions for how to obtain a service authorization]

What Happens After We Get Your Service Authorization Request

[Plan] has a review team to be sure you receive medically necessary services. Doctors, nurses, and licensed clinicians are on the review team. Their job is to be sure the treatment or service you asked for is medically needed and right for you. They do this by checking your treatment plan against medically acceptable standards. The standards we use to determine what is medically necessary are not allowed to be more restrictive than those that are used by DMAS.

Any decision to deny a service authorization request or to approve it for an amount that is less than requested is called an adverse benefit determination (decision). These decisions will be made by a qualified health care professional. If we decide that the requested service is not medically necessary, the decision will be made by a medical or behavioral health professional, who may be a doctor or other health care professional who typically provides the care you requested. You can request the specific medical standards, called clinical review criteria, used to make the decision for actions related to medical necessity.

After we get your request, we will review it under a standard or expedited (fast) review process. You or your doctor can ask for an expedited review if you believe that a delay will cause serious harm to your health. If your request for an expedited review is denied, we will tell you and your case will be handled under the standard review process.

Timeframes for Service Authorization Review

In all cases, we will review your request as quickly as your medical condition requires us to do so but no later than mentioned below.

Physical Health Services	**Service Authorization Review Timeframes**
Inpatient Hospital Services (Standard or Expedited Review Process)	Within 1 business day if we have all the information we need, or up to 3 business days if we need additional information, or as quickly as your condition requires.
Outpatient Services (Standard Review Process)	Within 3 business days if we have all the information we need, or up to 5 business days if we need additional information.
Outpatient Services (Expedited Review Process)	Within 72 hours from receipt of your request; or, as quickly as your condition requires.
Long Term Services and Supports ○ Includes CCC Plus Waiver services ○ EPSDT Personal Care and Private Duty Nursing ○ Nursing Facility ○ Long Stay Hospital ○ Hospice (Standard Review Process)	Within 5 business days from receipt of your request. Also see *Screening for Long Term Services and Supports* in Section 10 of this handbook.
Long Term Services and Supports Same as those listed above (Expedited Review Process)	Within 72 hours from receipt of your request; or, as quickly as your condition requires.

Behavioral Health Services	Service Authorization Review Timeframes
Outpatient Including Community Mental Health Rehabilitation Services (Standard Review Process)	Within 3 business days if we have all of the information we need, or up to 5 business days if we need additional information, or as quickly as your condition requires.
Inpatient (Standard Review)	Within 1 business day if we have all of the information we need, or up to 3 business days if we need additional information, or as quickly as your condition requires.
Inpatient (Expedited Review)	Within 3 hours.
Other Urgent Services	Within 24 hours or as quickly as your condition requires.

Pharmacy Services	Service Authorization Review Timeframes
Pharmacy services	We must provide decisions by telephone or other telecommunication device within 24 hours.
There may be an instance where your medication requires a service authorization, and your prescribing physician cannot readily provide authorization information to us, for example over the weekend or on a holiday. If your pharmacist believes that your health would be compromised without the benefit of the drug, we may authorize a 72-hour emergency supply of the prescribed medication. This process provides you with a short-term supply of the medications you need and gives time for your physician to submit an authorization request for the prescribed medication.	

If we need more information to make either a standard or expedited decision about your service request, we will:

- Write and tell you and your provider what information is needed. If your request is in an expedited review, we will call you or your provider right away and send a written notice later.
- Tell you why the delay is in your best interest.

- Make a decision no later than 14 days from the day we asked for more information.

You, your provider, or someone you trust may also ask us to take more time to make a decision. This may be because you have more information to give [Plan] to help decide your case. This can be done by calling [plan enters phone number(s) and address].

You or someone you trust can file a complaint with [Plan] if you don't agree with our decision to take more time to review your request. You or someone you trust can also file a complaint about the way [Plan] handled your service authorization request to the State through the CCC Plus Helpline at 1-844-374-9159 or TDD 1-800-817-6608. Also see *Your Right to File a Complaint*, in Section 15 of this handbook.

Benefit Determination

We will notify you with our decision by the date our time for review has expired. But if for some reason you do not hear from us by that date, it is the same as if we denied your service authorization request. If you disagree with our decision, you have the right to file an appeal with us. Also see *Your Right to Appeal*, in Section 15 in this handbook.

We will tell you and your provider in writing if your request is denied. A denial includes when the request is approved for an amount that is less than the amount requested. We will also tell you the reason for the decision and the contact name, address, and telephone number of the person responsible for making the adverse determination. We will explain what options for appeals you have if you do not agree with our decision. Also see *Your Right to Appeal*, in Section 15 of this handbook.

Advance Notice

In most cases, if we make a benefit determination to reduce, suspend or end a service we have already approved and that you are now getting, we must tell you at least 10 days before we make any changes to the service. Also see *Continuation of Benefits* in Section 15 of this handbook.

Post Payment Review

If we are checking on care or services that you received in the past, we perform a provider post payment review. If we deny payment to a provider for a service, we will send a notice to you and your provider the day the payment is denied. You will not have to pay for any care you received that was covered by [Plan] even if we later deny payment to the provider.

15. Appeals, State Fair Hearings, and Complaints (Grievances)

Your Right to Appeal

You have the right to appeal any adverse benefit determination (decision) by [Plan] that you disagree with that relates to coverage or payment of services.

For example, you can appeal if [Plan] denies:

- A request for a health care service, supply, item or drug that you think you should be able to get, or
- A request for payment of a health care service, supply, item, or drug that [Plan] denied.

You can also appeal if [Plan] stops providing or paying for all or a part of a service or drug you receive through CCC Plus that you think you still need.

Authorized Representative

You may wish to authorize someone you trust to appeal on your behalf. This person is known as your authorized representative. You must inform [Plan] of the name of your authorized representative. You can do this by calling our Member Services Department at one of the phone numbers below. We will provide you with a form that you can fill out and sign stating who your representative will be.

Adverse Benefit Determination

There are some treatments and services that you need to get approval for before you receive them or in order to be able to continue receiving them. Asking for approval of a treatment or service is called a service authorization request. This process is described earlier in this handbook. Any decision we make to deny a service authorization request or to approve it for an amount that is less than requested is called an adverse benefit determination. Refer to *Service Authorization and Benefit Determinations* in Section 14 of this handbook.

How to Submit Your Appeal

If you are not satisfied with a decision we made about your service authorization

request, you have 60 calendar days after hearing from us to file an appeal. You can do this yourself or ask someone you trust to file the appeal for you. You can call Member Services at one of the numbers below if you need help filing an appeal or if you need assistance in another language or require an alternate format. We will not treat you unfairly because you file an appeal.

You can file your appeal by phone or in writing. You can send the appeal as a standard appeal or an expedited (fast) appeal request.

You or your doctor can ask to have your appeal reviewed under the expedited process if you believe your health condition or your need for the service requires an expedited review. Your doctor will have to explain how a delay will cause harm to your physical or behavioral health. If your request for an expedited appeal is denied, we will tell you and your appeal will be reviewed under the standard process.

Send your Appeal request to: [plan address, FAX, phone]. If you send your standard appeal by phone, it must be followed up in writing. Expedited process appeals submitted by phone do not require you to submit a written request.

Continuation of Benefits

In some cases you may be able to continue receiving services that were denied by us while you wait for your appeal to be decided. You may be able to continue the services that are scheduled to end or be reduced if you ask for an appeal:

- Within ten days from being told that your request is denied or care is changing; or
- By the date the change in services is scheduled to occur.

If your appeal results in another denial you may have to pay for the cost of any continued benefits that you received if the services were provided solely because of the requirements described in this Section.

What Happens After We Get Your Appeal

Within *[plan provides timeframe for acknowledging appeal]* days, we will send you a letter to let you know we have received and are working on your appeal.

Appeals of clinical matters will be decided by qualified health care professionals who did not make the first decision and who have appropriate clinical expertise in treatment of your condition or disease.

Before and during the appeal, you or your authorized representative can see your case file, including medical records and any other documents and records being used to make a decision on your case. This information is available at no cost to you.

You can also provide information that you want to be used in making the appeal decision in person or in writing. *[Plan provides where the Member can call or send information].*

You can also call Member Services at one of the numbers below if you are not sure what information to give us.

Timeframes for Appeals

Standard Appeals

If we have all the information we need we will tell you our decision within 30 days of when we receive your appeal request. We will tell you within 2 calendar days after receiving your appeal if we need more information. A written notice of our decision will be sent within [Plan enters timeframe] calendar days from when we make the decision.

Expedited Appeals

If we have all the information we need, expedited appeal decisions will be made within 72 hours receipt of your appeal. We will tell you within 2 calendar days after receiving your appeal if we need more information. We will tell you our decision by phone and send a written notice within [plan enters timeframe] calendar days from when we make the decision.

If We Need More Information

If we can't make the decision within the needed timeframes because we need more information we will:

- Write you and tell you what information is needed. If your request is in an expedited review, we will call you right away and send a written notice later;
- Tell you why the delay is in your best interest; and
- Make a decision no later than 14 *additional days* from the timeframes described above.

You, your provider, or someone you trust may also ask us to take more time to make a decision. This may be because you have more information to give [Plan] to help decide your case. This can be done by calling or writing to: *[plan enters appropriate contact information and any additional instructions].*

You or someone you trust can file a complaint with [Plan] if you do not agree with our decision to take more time to review your appeal. You or someone you trust can also file a complaint about the way [Plan] handled your appeal to the State through the CCC Plus Help Line at 1-844-374-9159 or TDD 1-800-817-6608.

If we do not tell you our decision about your appeal on time, you have the right to appeal to the State through the State Fair Hearing process. An untimely response by us is considered a valid reason for you to appeal further through the State Fair Hearing process.

Written Notice of Appeal Decision

We will tell you and your provider in writing if your request is denied or approved in an amount less than requested. We will also tell you the reason for the decision and the contact name, address, and telephone number of the person responsible for making the adverse determination. We will explain your right to appeal through the State Fair Hearing Process if you do not agree with our decision.

Your Right to a State Fair Hearing

If you disagree with our decision on your appeal request, you can appeal directly to DMAS. This process is known as a State Fair Hearing. You may also submit a request for a State Fair Hearing if we deny payment for covered services or if we do not respond to an appeal request for services within the times described in this handbook. The State requires that you first exhaust (complete) [Plan]

appeals process before you can file an appeal request through the State Fair Hearing process. If we do not respond to your appeal request timely DMAS will count this as an *exhausted appeal*.

Standard or Expedited Review Requests

For standard requests, appeals will be heard and DMAS will give you an answer generally within 90 days from the date you filed your appeal. If you want your State Fair Hearing to be handled quickly, you must write "EXPEDITED REQUEST" on your appeal request. You must also ask your doctor to send a letter to DMAS that explains why you need an expedited appeal. DMAS will tell you if you qualify for an expedited appeal within 72 hours of receiving the letter from your doctor.

Authorized Representative

You can give someone like your PCP, provider, or friend or family Member written permission to help you with your State Fair Hearing request. This person is known as your authorized representative.

Where to Send the State Fair Hearing Request

You or your representative must send your standard or expedited appeal request to DMAS by internet, mail, fax, email, telephone, in person, or through other commonly available electronic means. Send State Fair Hearing requests to DMAS within no more than 120 calendar days from the date of our final decision. You may be able to appeal after the 120-day deadline in special circumstances with permission from DMAS.

You may write a letter or complete a Virginia Medicaid Appeal Request Form. The form is available at your local Department of Social Services or on the DMAS website at http://www.dmas.virginia.gov/Content_pgs/appeal-home.aspx. You should also send DMAS a copy of the letter we sent to you in response to your Appeal.

You must sign the appeal request and send it to:

Appeals Division
Department of Medical Assistance Services
600 E. Broad Street

Richmond, Virginia 23219
Fax: (804) 452-5454
Standard and Expedited Appeals may also be made by calling (804) 371-8488.

After You File Your State Fair Hearing Appeal

DMAS will notify you of the date, time, and location of the scheduled hearing. Most hearings can be done by telephone.

State Fair Hearing Timeframes

Expedited Appeal

If you qualify for an expedited appeal, DMAS will give you an answer to your appeal within 72 hours of receiving the letter from your doctor. If DMAS decides right away that you win your appeal, they will send you their decision within 72 hours of receiving the letter from your doctor. If DMAS does not decide right away, you will have an opportunity to participate in a hearing to present your position. Hearings for expedited decisions are usually held within one or two days of DMAS receiving the letter from your doctor. DMAS still has to give you an answer within 72 hours of receiving your doctor's letter.

Standard Appeal

If your request is not an expedited appeal, or if DMAS decides that you do not qualify for an expedited appeal, DMAS will generally give you an answer within 90 days from the date you filed your appeal. You will have an opportunity to participate in a hearing to present your position before a decision is made.

Continuation of Benefits

In some cases you may be able to continue receiving services that were denied by us while you wait for your State Fair Hearing appeal to be decided. You may be able to continue the services that are scheduled to end or be reduced if you ask for an appeal:

- Within ten days from being told that your request is denied or care is changing;
- By the date the change in services is scheduled to occur.

Your services will continue until you withdraw the appeal, the original authorization period for your service ends, or the State Fair Hearing Officer issues a decision that is not in your favor. **You may, however, have to repay [Plan] for any services you receive during the continued coverage period if [Plan's] adverse benefit determination is upheld and the services were provided solely because of the requirements described in this Section.**

If the State Fair Hearing Reverses the Denial

If services were not continued while the State Fair Hearing was pending

If the State Fair Hearing decision is to reverse the denial, [Plan] must authorize or provide the services under appeal as quickly as your condition requires and no later than 72 hours from the date [Plan] receives notice from the State reversing the denial.

If services were provided while the State Fair Hearing was pending

If the State Fair hearing decision is to reverse the denial and services were provided while the appeal is pending, [Plan] must pay for those services, in accordance with State policy and regulations.

If You Disagree with the State Fair Hearing Decision

The State Fair Hearing decision is the final administrative decision rendered by the Department of Medical Assistance Services. If you disagree with the Hearing Officer's decision you may appeal it to your local circuit court.

Your Right to File a Complaint (Grievance)

[Plan] will try its best to deal with your concerns as quickly as possible to your satisfaction. Depending on what type of concern you have, it will be handled as a complaint (also known as a grievance) or as an appeal.

Timeframe for Complaints

You can file a complaint with us at any time.

What Kinds of Problems Should be Complaints

The complaint process is used for concerns related to quality of care, waiting times, and customer service. Here are examples of the kinds of problems handled by the [Plan's] complaint process.

Complaints about quality

- You are unhappy with the quality of care, such as the care you got in the hospital.

Complaints about privacy

- You think that someone did not respect your right to privacy or shared information about you that is confidential or private.

Complaints about poor customer service

- A health care provider or staff was rude or disrespectful to you.
- [Plan] staff treated you poorly.
- [Plan] is not responding to your questions.
- You are not happy with the assistance you are getting from your Care Coordinator.

Complaints about accessibility

- You cannot physically access the health care services and facilities in a doctor or provider's office.
- You were not provided requested reasonable accommodations that you needed in order to participate meaningfully in your care.

Complaints about communication access

- Your doctor or provider does not provide you with a qualified interpreter for the deaf or hard of hearing or an interpreter for another language during your appointment.

Complaints about waiting times

- You are having trouble getting an appointment, or waiting too long to get it.

- You have been kept waiting too long by doctors, pharmacists, or other health professionals or by Member Services or other [plan] staff.

Complaints about cleanliness

- You think the clinic, hospital or doctor's office is not clean.

Complaints about communications from us

- You think we failed to give you a notice or letter that you should have received.
- You think the written information we sent you is too difficult to understand.
- You asked for help in understanding information and did not receive it.

There Are Different Types of Complaints

You can make an internal complaint and/or an external complaint. An internal complaint is filed with and reviewed by [Plan]. An external complaint is filed with and reviewed by an organization that is not affiliated with [plan].

Internal Complaints

To make an internal complaint, call Member Services at the number below. You can also write your complaint and send it to us. If you put your complaint in writing, we will respond to your complaint in writing. You can file a complaint in writing, by mailing or faxing it to us at [Plan Name, FAX, address, etc.]

So that we can best help you, include details on who or what the complaint is about and any information about your complaint. [Plan] will review your complaint and request any additional information. You can call Member Services at the number below if you need help filing a complaint or if you need assistance in another language or format.

We will notify you of the outcome of your complaint within a reasonable time, but no later than 30 calendar days after we receive your complaint.

If your complaint is related to your request for an expedited appeal, we will respond within 24 hours after the receipt of the complaint.

External Complaints

You Can File a Complaint with the CCC Plus Helpline

You can make a complaint about [plan] to the CC Plus Helpline. Contact the CCC Plus Helpline at 1-844-374-9159 or TDD 1-800-817-6608.

You Can File a Complaint with the Office for Civil Rights

You can make a complaint to the Department of Health and Human Services' Office for Civil Rights if you think you have not been treated fairly. For example, you can make a complaint about disability access or language assistance. You can also visit http://www.hhs.gov/ocr for more information.

You may contact the local Office for Civil Rights office at:

Office of Civil Rights- Region III

Department of Health and Human Services

150 S Independence Mall West Suite 372

Public Ledger Building

Philadelphia, PA 19106

1-800-368-1019

Fax: 215-861-4431

TDD: 1-800-537-7697

You Can File a Complaint with the Office of the State Long-Term Care Ombudsman

The State Long-Term Care Ombudsman serves as an advocate for older persons receiving long-term care services. Local Ombudsmen provide older Virginians and their families with information, advocacy, complaint counseling, and assistance in resolving care problems.

The State's Long-Term Care Ombudsman program offers assistance to persons receiving long term care services, whether the care is provided in a nursing facility or assisted living facility, or through community-based services to assist persons still living at home. A Long-Term Care Ombudsman does not work for the facility, the State, or [Plan]. This helps them to be fair and objective in resolving problems

and concerns.

The program also represents the interests of long-term care consumers before state and federal government agencies and the General Assembly.

The State Long-Term Care Ombudsman can help you if you are having a problem with [Plan] or a nursing facility. The State Long-Term Care Ombudsman is not connected with us or with any insurance company or health plan. The services are free.

Office of the State Long-Term Care Ombudsman

1-800-552-5019 This call is free.

1-800-464-9950

This number is for people who have hearing or speaking problems. You must have special telephone equipment to call it.

Virginia Office of the State Long-Term Care Ombudsman

Virginia Department for Aging and Rehabilitative Services

8004 Franklin Farms Drive

Henrico, Virginia 23229

804-662-9140

http://www.ElderRightsVA.org

16. Member Rights

Your Rights

It is the policy of *[Plan]* to treat you with respect. We also care about keeping a high level of confidentiality with respect for your dignity and privacy. As a CCC Plus Member you have certain rights. You have the right to:

- Receive timely access to care and services;
- Take part in decisions about your health care, including your right to choose your providers from *[plan]* network providers and your right to refuse treatment;
- Choose to receive long term services and supports in your home or community or in a nursing facility;
- Confidentiality and privacy about your medical records and when you get treatment;
- Receive information and to discuss available treatment options and alternatives presented in a manner and language you understand;
- Get information in a language you understand - you can get oral translation services free of charge;
- Receive reasonable accommodations to ensure you can effectively access and communicate with providers, including auxiliary aids, interpreters, flexible scheduling, and physically accessible buildings and services;
- Receive information necessary for you to give informed consent before the start of treatment;
- Be treated with respect and dignity;
- Get a copy of your medical records and ask that the records be amended or corrected;
- Participate in decisions regarding your healthcare, including the right to refuse treatment;
- Be free from restraint or seclusion unless ordered by a physician when there is an imminent risk of bodily harm to you or others or when there is a

specific medical necessity. Seclusion and restraint will never be used a s a means of coercion, discipline, retaliation, or convenience;

- Get care in a culturally competent manner including without regard to disability, gender, race, health status, color, age, national origin, sexual orientation, marital status or religion;
- Be informed of where, when and how to obtain the services you need from *[Plan]*, including how you can receive benefits from out-of-network providers if the services are not available in [Plan name's] network.
- Complain about *[Plan]* to the State. You can call the CCC Plus Helpline at 1-844-374-9159 or TDD 1-800-817-6608 to make a complaint about us.
- Appoint someone to speak for you about your care and treatment and to represent you in an Appeal;
- Make advance directives and plans about your care in the instance that you are not able to make your own health care decisions. See Section 17 of this handbook for information about Advance Directives.
- Change your CCC Plus health plan once a year for any reason during open enrollment or change your MCO after open enrollment for an approved reason. Reference Section 2 of this handbook or call the CCC Plus Helpline at 1-844-374-9159 or TDD 1-800-817-6608 or visit the website at cccplusva.com for more information.
- Appeal any adverse benefit determination (decision) by *[Plan]* that you disagree with that relates to coverage or payment of services. See *Your Right to Appeal* in this Section 15 of the handbook.
- File a complaint about any concerns you have with our customer service, the services you have received, or the care and treatment you have received from one of our network providers. See *Your Right to File a Complaint* in Section 15 of this handbook.
- To receive information from us about our plan, your covered services, providers in our network, and about your rights and responsibilities.
- To make recommendations regarding our member rights and responsibility policy, for example by joining our Member Advisory Committee (as

described later in this Section of the handbook.)

Your Right to be Safe

Everyone has the right to live a safe life in the home or setting of their choice. Each year, many older adults and younger adults who are disabled are victims of mistreatment by family members, by caregivers and by others responsible for their well-being. If you, or someone you know, is being abused, physically, is being neglected, or is being taken advantage of financially by a family member or someone else, you should call your local department of social services or the Virginia Department of Social Services' 24-hour, toll-free hotline at: 1-888 832-3858. You can make this call anonymously; you do not have to provide your name. The call is free.

They can also provide a trained local worker who can assist you and help you get the types of services you need to assure that you are safe.

Your Right to Confidentiality

[Plan] will only release information if it is specifically permitted by state and federal law or if it is required for use by programs that review medical records to monitor quality of care or to combat fraud or abuse.

[Plan] staff will ask questions to confirm your identity before we discuss or provide any information regarding your health information.

Plan inserts information on confidentiality consistent with confidentiality requirements, including special rules related to substance use disorder and addiction, recovery, and treatment services.

Your Right to Privacy

Plan inserts information on privacy practices as set forth in 45 CFR parts 160 and 164 subparts A and E, applies, request and receive a copy of his or her medical records, and request that they be amended or corrected, as specified in 45 CFR 164.524 and 164.526.

How to Join the Member Advisory Committee

[Plan] would like you to help us improve our health plan. We invite you to join our

Member Advisory Committee. On the committee, you can let us know how we can better serve you. Going to these meetings will give you and your caregiver or family Member the chance to help plan meetings and meet other Members in the community. These educational meetings are held once every three months. If you would like to attend or would like more information, please contact [Plan] Member Services using one of the numbers below.

We Follow Non-Discrimination Policies

You cannot be treated differently because of your race, color, national origin, disability, age, religion, gender, marital status, pregnancy, childbirth, sexual orientation, or medical conditions.

If you think that you have not been treated fairly for any of these reasons, call the Department of Health and Human Services, Office for Civil Rights at 1-800-368-1019. TTY users should call 1-800-537-7697. You can also visit http://www.hhs.gov/ocr for more information.

[Plan] complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

Spanish

[Plan] cumple con las leyes federales de derechos civiles aplicables y no discrimina por motivos de raza, color, nacionalidad, edad, discapacidad o sexo.

Korean

[Plan]은(는) 관련 연방 공민권법을 준수하며 인종, 피부색, 출신 국가, 연령, 장애 또는 성별을 이유로 차별하지 않습니다.

Vietnamese

[Plan] tuân thủ luật dân quyền hiện hành của Liên bang và không phân biệt đối xử dựa trên chủng tộc, màu da, nguồn gốc quốc gia, độ tuổi, khuyết tật, hoặc giới tính.

Chinese

[Plan] 遵守適用的聯邦民權法律規定，不因種族、膚色、民族血統、年齡、殘障 或性別而歧視任何人。

Arabic

[Plan] أويلتزم اللون أو العرق أساس على يميز ولا بها المعمول الفدرالية المدنية الحقوق بقوانين الجنس أو الإعاقة أو السن أو الوطني الأصل.

Tagalog

Sumusunod ang [Plan] sa mga naaangkop na Pederal na batas sa karapatang sibil at hindi nandidiskrimina batay sa lahi, kulay, bansang pinagmulan, edad, kapansanan o kasarian.

Farsi

[Plan] از قوانین حقوق مدنی فدرال مربوطه تبعیت می کند و هیچگونه تبعیضی بر اساس نژاد، رنگ پوست، اصلیت ملیتی، سن، ناتوانی یا جنسیت افراد قایل نمی شود.

Amharic

[Plan] የፌደራል ሲቪል መብቶችን መብት የሚያከብር ሲሆን ሰዎችን በዘር፡ በቆዳ ቀለም፣ በዘር ሃረግ፣ በእድሜ፣ በአካል ጉዳት ወይም በጾታ ማንኛውንም ሰው አያገልም።

Urdu

[Plan] ہے کرتا تعمیل کی قوانین کے حقوق شہری وفاقی اطلاق ل ِ قاب

کرتا۔ نہیں امتیاز پر بنیاد کی جنس یا معذوری ،عمر ،قومیت ، رنگ ،نسل کہ یہ اور

French

[Plan] respecte les lois fédérales en vigueur relatives aux droits civiques et ne pratique aucune discrimination basée sur la race, la couleur de peau, l'origine nationale, l'âge, le sexe ou un handicap.

Russian

[Plan] соблюдает применимое федеральное законодательство в области гражданских прав и не допускает дискриминации по признакам расы, цвета кожи, национальной принадлежности, возраста, инвалидности или пола.

Hindi

[Plan] लागूहोने योग्य संघीय नागरक अिधकार क़ाननू का पालन करता ह और जात, रंग, राय मूल, आयु, वकलांगता, या लग के आधार पर भेदभाव नह करता ह।

German

[Plan] erfüllt geltenden bundesstaatliche Menschenrechtsgesetze und lehnt jegliche Diskriminierung aufgrund von Rasse, Hautfarbe, Herkunft, Alter, Behinderung oder Geschlecht ab.

Bengali

[Plan] যাজয্ ফডারল নাগিরক অিধকার আইন মেন চেল এবং জাত, রঙ, জাতীয় উৎপিত্ত, বয়স, অমতা, বা লের ভিত্তেত বষময্ কের না।

Bassa

[Plan] Nyɔ ɓě kpā nyɔǔn-dyù gbo-gmā -gmà ɓě dyi ké wa ní ge nyɔǔn-dyù mú dyììn ɖé ɓóɖó-dù nyɔā sā kā ɛ mú, mɔɔ kà nyɔā dyɔā -kù nyu nìā kɛ mú, mɔɔ ɓóɖó ɓā nyɔā sā kā ɛ mú, mɔɔ zājĩ kà nyɔā ɖǎ nyuɛ mú, mɔɔ nyɔā mɛ kā dyíɛ mú, mɔɔ nyɔā mɛ mā gàa, mɔɔ nyɔā mɛ mā màa kɛɛ mú.

17. Member Responsibilities

Your Responsibilities

As a Member, you also have some responsibilities. These include:

- Present your [Plan] Membership card whenever you seek medical care.
- Provide complete and accurate information to the best of your ability on your health and medical history.
- Participate in your care team meetings, develop an understanding of your health condition, and provide input in developing mutually agreed upon treatment goals to the best of your ability.
- Keep your appointments. If you must cancel, call as soon as you can.
- Receive all of your covered services from [Plan's] network.
- Obtain authorization from [plan] prior to receiving services that require a service authorization review (see Section 14).
- Call [Plan] whenever you have a question regarding your Membership or if you need assistance toll-free at one of the numbers below.
- Tell [Plan] when you plan to be out of town so we can help you arrange your services.
- Use the emergency room only for real emergencies.
- Call your PCP when you need medical care, even if it is after hours.
- Tell [Plan] when you believe there is a need to change your plan of care.
- Tell us if you have problems with any health care staff. Call Member Services at one of the numbers below.
- Call Member Services at one of the phone numbers below about any of the following:
    - If you have any changes to your name, your address, or your phone number. Report these also to your case worker at your local Department of Social Services.
    - If you have any changes in any other health insurance coverage, such as

from your employer, your spouse's employer, or workers' compensation.

- If you have any liability claims, such as claims from an automobile accident.
- If you are admitted to a nursing facility or hospital.
- If you get care in an out-of-area or out-of-network hospital or emergency room.
- If your caregiver or anyone responsible for you changes.
- If you are part of a clinical research study.

Advance Directives

You have the right to say what you want to happen if you are unable to make health care decisions for yourself. There may be a time when you are unable to make health care decisions for yourself. Before that happens to you, you can:

- Fill out a written form to give someone the right to make health care decisions for you if you become unable to make decisions for yourself.
- Give your doctors written instructions about how you want them to handle your health care if you become unable to make decisions for yourself.

The legal document that you can use to give your directions is called an advance directive. An advance directive goes into effect only if you are unable to make health care decisions for yourself. Any person age 18 or over can complete an advance directive. There are different types of advance directives and different names for them. Examples are a living will, a durable power of attorney for health care, and advance care directive for health care decisions.

You do not have to use an advance directive, but you can if you want to. Here is what to do:

Where to Get the Advance Directives Form

You can get the Virginia Advance Directives form at: http://www.vdh.virginia.gov/OLC/documents/2011/pdfs/2011-VA-AMD-Simple.pdf.

You can also get the form from your doctor, a lawyer, a legal services agency, or a

social worker. Organizations that give people information about Medicaid [plans should insert examples of those organizations] may also have advance directive forms. [Insert if applicable: You can also contact Member Services to ask for the forms.]

Completing the Advance Directives Form

Fill it out and sign the form. The form is a legal document. You may want to consider having a lawyer help you prepare it. There may be free legal resources available to assist you.

Share the Information with People You Want to Know About It

Give copies to people who need to know about it. You should give a copy of the Living Will, Advance Care Directive, or Power of Attorney form to your doctor. You should also give a copy to the person you name as the one to make decisions for you. You may also want to give copies to close friends or family members. Be sure to keep a copy at home.

If you are going to be hospitalized and you have signed an advance directive, take a copy of it to the hospital. The hospital will ask you whether you have signed an advance directive form and whether you have it with you. If you have not signed an advance directive form, the hospital has forms available and will ask if you want to sign one.

We Can Help You Get or Understand Advance Directives Documents

Your Care Coordinator can help you understand or get these documents. They do not change your right to quality health care benefits. The only purpose is to let others know what you want if you can't speak for yourself.

Remember, it is your choice to fill out an advance directive or not. You can revoke or change your advance care directive or power of attorney if your wishes about your health care decisions or authorized representative change.

Other Resources

You may also find information about advance directives in Virginia at: www.virginiaadvancedirectives.org .

You can store your advance directive at the Virginia Department of Health Advance Healthcare Directive Registry: www.virginiaregistry.org/.

If Your Advance Directives Are Not Followed

If you have signed an advance directive, and you believe that a doctor or hospital did not follow the instructions in it, you may file a complaint with the following organizations.

For complaints about doctors and other providers, contact the Enforcement Division at the Virginia Department of Health Professions:

CALL	Virginia Department of Health Professions: Toll-Free Phone: 1-800-533-1560 Local Phone: 804-367-4691
WRITE	Virginia Department of Health Professions Enforcement Division 9960 Mayland Drive, Suite 300 Henrico, Virginia 23233-1463
FAX	804-527-4424
EMAIL	enfcomplaints@dhp.virginia.gov
WEBSITE	http://www.dhp.virginia.gov/Enforcement/complaints.htm

For complaints about nursing facilities, inpatient and outpatient hospitals, abortion facilities, home care organizations, hospice programs, dialysis facilities, clinical laboratories, and health plans (also known as managed care organizations), contact the Office of Licensure and Certification at the Virginia Department of Health:

CALL	Toll-Free Phone: 1-800-955-1819 Local Phone: 804-367-2106
WRITE	Virginia Department of Health Office of Licensure and Certification 9960 Mayland Drive, Suite 401 Henrico, Virginia 23233-1463
FAX	804-527-4503
EMAIL	OLC-Complaints@vdh.virginia.gov
WEBSITE	http://www.vdh.state.va.us/olc/complaint/

18. Fraud, Waste, and Abuse

Plan includes relevant information and instructions including but not limited to the subsections below.

What is Fraud, Waste, and Abuse

Fraud is an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable Federal or State law.

Waste includes overutilization, underutilization, or misuse of resources. Waste typically is not an intentional act, but does result in spending that should not have occurred. As a result, waste should be reported so that improper payments can be identified and corrected

Abuse includes practices that are inconsistent with sound fiscal, business, or medical practice, and result in unnecessary cost to the Medicaid program, payment for services that are not medically necessary, or fail to meet professionally recognized health care standards.

Common types of health care fraud, waste, and abuse include:

- Medical identity theft
- Billing for unnecessary items or services
- Billing for items or services not provided
- Billing a code for a more expensive service or procedure than was performed (known as up-coding)
- Charging for services separately that are generally grouped into one rate (Unbundling)
- Items or services not covered
- When one doctor receives a form of payment in return for referring a patient to another doctor. These payments are called “kickbacks.”

How Do I Report Fraud, Waste, or Abuse

Plan Instructions

If you would prefer to refer your fraud, waste, or abuse concerns directly to the State, you can report to the contacts listed below.

Department of Medical Assistance Services Fraud Hotline

Phone: 1-800-371-0824 or

1-866-486-1971 or

(804) 786-1066

Virginia Medicaid Fraud Control Unit (Office of the Attorney General)

Email: MFCU_mail@oag.state.va.us

Fax: 804-786-3509

Mail: Office of the Attorney General

Medicaid Fraud Control Unit

202 North Ninth Street

Richmond, VA 23219

Virginia Office of the State Inspector General

Fraud, Waste, and Abuse Hotline

Phone: 1-800-723-1615

Fax: 804-371-0165

Email: covhotline@osig.virginia.gov

Mail: State FWA Hotline

101 N. 14th Street

The James Monroe Building 7th Floor

Richmond, VA 23219

19. Other Important Resources

[*Plan may insert this Section to provide additional information resources, such as county aging and disability resource centers, choice counselors, CCC Plus Helplines, or area agencies on aging.*]

The Virginia Department for the Deaf and Hard of Hearing (VDDHH)

The Technology Assistance Program (TAP) provides telecommunication equipment to qualified applicants whose disabilities prevent them from using a standard telephone. VDDHH outreach specialists can also provide information and referral for assistive technology devices.

(804) 662-9502 (Voice / TTY)
1-800-552-7917 (Voice / TTY)
(804) 662-9718 (Fax)
1602 Rolling Hills Drive, Suite 203
Richmond, VA 23229-5012

http://www.vddhh.org

20. Important Words and Definitions Used in this Handbook

- Adverse benefit determination: Any decision to deny a service authorization request or to approve it for an amount that is less than requested.
- Appeal: A way for you to challenge an adverse benefit determination (such as a denial or reduction of benefits) made by [plan] if you think we made a mistake. You can ask us to change a coverage decision by filing an appeal.
- Activities of daily living: The things people do on a normal day, such as eating, using the toilet, getting dressed, bathing, or brushing the teeth.
- Balance billing: A situation when a provider (such as a doctor or hospital) bills a person more than [Plan]'s cost-sharing amount for services. We do not allow providers to "balance bill" you. Call Member Services if you get any bills that you do not understand.
- Brand name drug: A prescription drug that is made and sold by the company that originally made the drug. Brand name drugs have the same ingredients as the generic versions of the drugs. Generic drugs are made and sold by other drug companies.
- Care Coordinator: One main person from our [plan] who works with you and with your care providers to make sure you get the care you need.
- Care coordination: A person-centered individualized process that assists you in gaining access to needed services. The Care Coordinator will work with you, your family Members, if appropriate, your providers and anyone else involved in your care to help you get the services and supports that you need.
- Care plan: A plan for what health and support services you will get and how you will get them.
- Care team: A care team may include doctors, nurses, counselors, or other health professionals who are there to help you get the care you need. Your care team will also help you make a care plan.
- CCC Plus Helpline: an Enrollment Broker that DMAS contracts with to

perform choice counseling and enrollment activities.

- Centers for Medicare & Medicaid Services (CMS): The federal agency in charge of Medicare and Medicaid programs.
- Coinsurance: See the definition for cost sharing.
- Complaint: A written or spoken statement saying that you have a problem or concern about your covered services or care. This includes any concerns about the quality of your care, our network providers, or our network pharmacies. The formal name for "making a complaint" is "filing a grievance."
- Copayment: See the definition for cost sharing.
- Cost sharing: the costs that members may have to pay out of pocket for covered services. This term generally includes deductibles, coinsurance, and copayments, or similar charges. Also see the definition for patient pay.
- Coverage decision: A decision about what benefits we cover. This includes decisions about covered drugs and services or the amount we will pay for your health services.
- Covered drugs: The term we use to mean all of the prescription drugs covered by [plan].
- Covered services: The general term we use to mean all of the health care, long-term services and supports, supplies, prescription and over-the-counter drugs, equipment, and other services covered by [plan].
- Durable medical equipment: Certain items your doctor orders for you to use at home. Examples are walkers, wheelchairs, or hospital beds.
- Emergency medical condition: An emergency means your life could be threatened or you could be hurt permanently (disabled) if you don't get care quickly. If you are pregnant, it could mean harm to the health of you or your unborn baby.
- Emergency medical transportation: Your condition is such that you are unable to go to the hospital by any other means but by calling 911 for an ambulance.

- Emergency room care: A hospital room staffed and equipped for the treatment of people that require immediate medical care and/or services.
- Emergency services: Services provided in an emergency room by a provider trained to treat a medical or behavioral health emergency.
- Excluded services: Services that are not covered under the Medicaid benefit.
- Fair hearing: See State Fair Hearing. The process where you appeal to the State on a decision made by us that you believe is wrong.
- Fee-for-service: The general term used to describe Medicaid services covered by the Department of Medical Assistance Services (DMAS).
- Generic drug: A prescription drug that is approved by the federal government to use in place of a brand name drug. A generic drug has the same ingredients as a brand name drug. It is usually cheaper and works just as well as the brand name drug.
- Grievance: A complaint you make about us or one of our network providers or pharmacies. This includes a complaint about the quality of your care.
- Habilitation services and devices: Services and devices that help you keep, learn, or improve skills and functioning for daily living.
- Health insurance: Type of insurance coverage that pays for health, medical and surgical expenses incurred by you.
- Health plan: An organization made up of doctors, hospitals, pharmacies, providers of long-term services, and other providers. It also has Care Coordinators to help you manage all your providers and services. They all work together to provide the care you need.
- Health risk assessment: A review of a patient's medical history and current condition. It is used to figure out the patient's health and how it might change in the future.
- Home health aide: A person who provides services that do not need the skills of a licensed nurse or therapist, such as help with personal care (like bathing, using the toilet, dressing, or carrying out the prescribed exercises).

Home health aides do not have a nursing license or provide therapy.

- Home health care: Health care services a person receives in the home including nursing care, home health aide services and other services.
- Hospice services: A program of care and support to help people who have a terminal prognosis live comfortably. A terminal prognosis means that a person has a terminal illness and is expected to have six months or less to live. An enrollee who has a terminal prognosis has the right to elect hospice. A specially trained team of professionals and caregivers provide care for the whole person, including physical, emotional, social, and spiritual needs.
- Hospitalization: The act of placing a person in a hospital as a patient.
- Hospital outpatient care: Care or treatment that does not require an overnight stay in a hospital.
- List of Covered Drugs (Drug List): A list of prescription drugs covered by [Plan]. [Plan] chooses the drugs on this list with the help of doctors and pharmacists. The Drug List tells you if there are any rules you need to follow to get your drugs. The Drug List is sometimes called a "formulary."
- Long-term services and supports (LTSS): A variety of services and supports that help elderly individuals and individuals with disabilities meet their daily needs for assistance, improve the quality of their lives, and maintain maximum independence. Examples include assistance with bathing, dressing, toileting, eating, and other basic activities of daily life and self-care, as well as support for everyday tasks such as laundry, shopping, and transportation. LTSS are provided over a long period of time, usually in homes and communities, but also in facility-based settings such as nursing facilities. Most of these services help you stay in your home so you don't have to go to a nursing facility or hospital.
- Medically Necessary: This describes the needed services to prevent, diagnose, or treat your medical condition or to maintain your current health status. This includes care that keeps you from going into a hospital or nursing facility. It also means the services, supplies, or drugs meet accepted standards of medical practice or as necessary under current

Virginia Medicaid coverage rules.

- Medicaid (or Medical Assistance): A program run by the federal and the state government that helps people with limited incomes and resources pay for long-term services and supports and medical costs. It covers extra services and drugs not covered by Medicare. Most health care costs are covered if you qualify for both Medicare and Medicaid.
- Medicare: The federal health insurance program for people 65 years of age or older, some people under age 65 with certain disabilities, and people with end-stage renal disease (generally those with permanent kidney failure who need dialysis or a kidney transplant). People with Medicare can get their Medicare health coverage through Original Medicare or a managed care plan (see "Health plan").
- Medicare-covered services: Services covered by Medicare Part A and Part B. All Medicare health plans must cover all of the services that are covered by Medicare Part A and Part B.
- Medicare-Medicaid enrollee: A person who qualifies for Medicare and Medicaid coverage. A Medicare-Medicaid enrollee is also called a "dual eligible beneficiary."
- Medicare Part A: The Medicare program that covers most medically necessary hospital, skilled nursing facility, home health, and hospice care.
- Medicare Part B: The Medicare program that covers services (like lab tests, surgeries, and doctor visits) and supplies (like wheelchairs and walkers) that are medically necessary to treat a disease or condition. Medicare Part B also covers many preventive and screening services.
- Medicare Part C: The Medicare program that lets private health insurance companies provide Medicare benefits through a Medicare Advantage Plan.
- Medicare Part D: The Medicare prescription drug benefit program. (We call this program "Part D" for short.) Part D covers outpatient prescription drugs, vaccines, and some supplies not covered by Medicare Part A or Part B or Medicaid.
- Member Services: A department within [plan] responsible for answering

your questions about your Membership, benefits, grievances, and appeals.

- Model of care: A way of providing high-quality care. The CCC Plus model of care includes care coordination and a team of qualified providers working together with you to improve your health and quality of life.
- Network: "Provider" is the general term we use for doctors, nurses, and other people who give you services and care. The term also includes hospitals, home health agencies, clinics, and other places that provide your health care services, medical equipment, and long-term services and supports. They are licensed or certified by Medicaid and by the state to provide health care services. We call them "network providers" when they agree to work with the [plan] and accept our payment and not charge our Members an extra amount. While you are a Member of [plan], you must use network providers to get covered services. Network providers are also called "plan providers."
- Network pharmacy: A pharmacy (drug store) that has agreed to fill prescriptions for [plan] Members. We call them "network pharmacies" because they have agreed to work with [plan]. In most cases, your prescriptions are covered only if they are filled at one of our network pharmacies.
- Non-participating provider: A provider or facility that is not employed, owned, or operated by [plan] and is not under contract to provide covered services to Members of [plan].
- Nursing facility: A medical care facility that provides care for people who cannot get their care at home but who do not need to be in the hospital. Specific criteria must be met to live in a nursing facility.
- Ombudsman: An office in your state that helps you if you are having problems with [plan] or with your services. The ombudsman's services are free.
- Out-of-network provider or Out-of-network facility: A provider or facility that is not employed, owned, or operated by [plan] and is not under contract to provide covered services to Members of [plan].

- Participating provider: Providers, hospitals, home health agencies, clinics, and other places that provide your health care services, medical equipment, and long-term services and supports that are contracted with [plan]. Participating providers are also “in-network providers” or “plan providers.”
- Patient Pay: The amount you may have to pay for long term care services based on your income. The Department of Social Services (DSS) must calculate your patient pay amount if you live in a nursing facility or receive CCC Plus Waiver services and have an obligation to pay a portion of your care. DSS will notify you and [plan] if you have a patient pay, including the patient pay amount (if any).
- Physician services: Care provided to you by an individual licensed under state law to practice medicine, surgery, or behavioral health.
- Plan: An organization made up of doctors, hospitals, pharmacies, providers of long-term services, and other providers. It also has Care Coordinators to help you manage all your providers and services. They all work together to provide the care you need.
- Prescription drug coverage: Prescription drugs or medications covered (paid) by your [plan]. Some over-the -counter medications are covered.
- Prescription drugs: A drug or medication that, by law, can be obtained only by means of a physician's prescription.
- Primary Care Physician (PCP): Your primary care physician (also referred to as your primary care provider) is the doctor who takes care of all of your health needs. They are responsible to provide, arrange, and coordinate all aspects of your health care. Often they are the first person you should contact if you need health care. Your PCP is typically a family practitioner, internist, or pediatrician. Having a PCP helps make sure the right medical care is available when you need it.
- Prosthetics and Orthotics: These are medical devices ordered by your doctor or other health care provider. Covered items include, but are not limited to, arm, back, and neck braces; artificial limbs; artificial eyes; and devices needed to replace an internal body part or function.

- Provider: A person who is authorized to provide your health care or services. Many kinds of providers participate with [plan], including doctors, nurses, behavioral health providers and specialists.
- Premium: A monthly payment a health plan receives to provide you with health care coverage.
- Private duty nursing services: skilled in-home nursing services provided by a licensed RN, or by an LPN under the supervision of an RN, to waiver members who have serious medical conditions or complex health care needs.
- Referral: In most cases you PCP must give you approval before you can use other providers in [Plan]'s network. This is called a referral.
- Rehabilitation services and devices: Treatment you get to help you recover from an illness, accident, injury, or major operation.
- Service area: A geographic area where a [plan] is allowed to operate. It is also generally the area where you can get routine (non-emergency) services.
- Service authorization: Also known as preauthorization. Approval needed before you can get certain services or drugs. Some network medical services are covered only if your doctor or other network provider gets an authorization from [plan].
- Skilled nursing care: care or treatment that can only be done by licensed nurses. Examples of skilled nursing needs include complex wound dressings, rehabilitation, tube feedings or rapidly changing health status.
- Skilled Nursing Facility (SNF): A nursing facility with the staff and equipment to give skilled nursing care and, in most cases, skilled rehabilitative services and other related health services.
- Specialist: A doctor who provides health care for a specific disease, disability, or part of the body.
- Urgently needed care (urgent care): Care you get for a non-life threatening sudden illness, injury, or condition that is not an emergency but needs care right away. You can get urgently needed care from out-of-network

providers when network providers are unavailable or you cannot get to them.

[*Plans may add a back cover for the Member Handbook that contains contact information for Member Services. Below is an example plans may use. Plans also may add a logo and/or photographs, as long as these elements do not make it difficult for Members to find and read the contact information.*]

[Plan] Member Services

CALL	[*Insert phone number(s).*] Calls to this number are free. [*Insert days and hours of operation, including information on the use of alternative technologies.*] Member Services also has free language interpreter services available for non-English speakers.
TTY	[*Insert number.*] [*Insert if plan uses a direct TTY number:* This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.] Calls to this number are free. [*Insert days and hours of operation.*]
FAX	[*Optional: Insert fax number.*]
WRITE	[*Insert address.*] [***Note**: Plans may add email addresses here.*]
WEB SITE	[*Insert URL.*]